EXPERIENCES OF COERCION AND TREATMENT PRESSURES AMONGST MENTAL HEALTH SERVICE USERS

HANNAH DUNCAN

A thesis submitted in partial fulfilment of the requirements of the University of East London for the degree of Doctor of Clinical Psychology

May 2013

Abstract

The existing body of literature indicates that psychiatric service-users commonly experience treatment pressures. In the research to date there has been a bias towards investigating (often compulsory) hospital admission and treatment at the expense of finding out about the wide range of experiences that service-users potentially perceive as treatment pressures. Similarly little research has explored the effects of these experiences over time, the processes that mediate them, or how they are managed. This research sought to explore these neglected issues, which is paramount for the development of a more ethical psychiatric service provision.

Ten mental health service-users were interviewed with regards to their experiences of treatment pressure; the effects of these experiences; and the processes involved in their management of them. A thematic analysis of these interviews was constructed. The overarching theme, 'experiencing and managing treatment pressure', was comprised of four themes: 'A personal experience', 'A relational experience', 'A culturally bound experience', and 'Taking control: "it's fight, flight or comply"'.

The analysis indicated that the experiences of treatment pressure had wide reaching and enduring effects for participants in terms of: their understanding of the world; their self-identity; their relationships with others; and their social category status. In order to manage these experiences and incorporate them into narratives about themselves participants appeared to 'take control' of their experiences in different and multiple ways. Managing their experiences in this way seemed to ameliorate the often highly distressing and disturbing effects of treatment pressures.

The thesis ends with a consideration of both clinical and research implications.

Acknowledgements

I would like to give my thanks to all the participants for generously giving their time and for talking so openly about their experiences. Thank you to Dave Harper for his valuable and constructive input throughout the development and write-up of this research. Thank you to George Szmukler for inspiring my interest in this topic. Special thanks to those around me who have provided encouragement and support.

Word count: 27,416 (29,376 with amendments)

Contents

Chapter 1: Introduction

> Coercion in psychiatry is an increasingly important area for clinical and research initiatives. Owing to the linkages with legal, human rights, and ethical issues, the number of individual questions that need to be addressed is enormous (Kallert, 2008, p.488).

1.1 Overview of chapter

In this chapter I outline the subject of this study: mental health service-users' experiences of treatment pressures. The term 'treatment pressures' is defined and explained in more detail below. Briefly, it refers to the pressures service-users experience with regards to treatments for their mental health, including the experience of coercion. Once defined, I will place the uses of coercion and treatment pressures within their historical and current contexts and critically review the existing empirical research concerning them. The chapter concludes with the rationale for the present study, its aims and research questions.

1.2 Literature review

1.2.1 Literature search

A literature search was conducted using the following databases: Web of Science and Medline (both via Web of Knowledge) and PsychINFO, PsychARTICLES and CINAHL Plus (via Ebsco). A full outline of the literature search is provided in appendix A.

1.2.2 Outline of literature generated

The vast majority of the papers identified concerned the experiences of psychiatric service-users. Of the papers read almost half explored the experiences of coercion amongst inpatients; of which half were quantitative studies. Less than 20% of the papers generated included the experiences of

outpatients; of which half adopted quantitative methods. Theoretical discussions of the issues constituted approximately 10% of the papers identified. A small number of studies explored staff/family views on the use of coercion/specific coercive treatments[1]. A very small number investigated the effectiveness of interventions (e.g. the use of joint crisis plans, provision of an information brochure on admission to hospital) aimed at reducing the experience of service-user coercion.

1.3 Terminology

Although this study concerns the broader term of 'treatment pressures', the term 'coercion' has been in use longer and has been the focus of most existing literature. This is defined below.

1.3.1 Coercion

Coercion: to persuade (an unwilling person) to do something by using force or threats (The Oxford English Dictionary, 1989).

Despite the wide use of coercion within psychiatric services (e.g. forced detention and/or treatment under mental health legislation, the use of restraint and seclusion) it is a concept poorly defined in the literature and has been subject to many interpretations (Høyer et al., 2002). For example Lovell (1996) conceptualised coercion as a continuum encompassing a wide range of practices. Szmukler and Appelbaum (2008) however suggested that 'coercion' only captures a snapshot of treatment pressures and that there are a wide range of practices employed to induce service-users to accept treatments they do not want to comply with. They suggest use of the umbrella term 'treatment pressures' as a more accurate depiction of these.

1.3.2 Treatment pressures

Szmukler and Appelbaum (2008) defined treatment pressures as the following:

[1] I will not discuss these due to limited space.

Persuasion

Where “discussion with the patient revolves around an arguably realistic appraisal of the benefits and risks of treatment…in the context of his or her value system” (Szmukler and Appelbaum, 2008, p.235).

Interpersonal leverage

When the nature of the relationship between the clinician and service-user (which Szmukler and Appelbaum suggested often entails dependency) is used to exert pressure on the service-user, to either please someone they have found helpful or avoid disappointing them.

Inducements

When a clinician offers a service-user something on the condition that they comply with treatment (e.g. a material reward) where the service-user will be no worse off in terms of a moral baseline[2] if they refuse.

Threats

When the thing offered by the clinician is something that, if refused, will leave the service-user worse off in terms of a moral baseline (such as help completing a benefit application form to which the person is ‘entitled’ to assistance) then this is considered a threat.

Compulsory treatment

This can occur either in the community or in hospital and is where non-adherence to treatment can be responded to with force supported by legal statute.

Szmukler and Appelbaum (2008) suggested that the above list ascends through a hierarchy of treatment pressures based on conceptual moral distinctions, and that greater justification is needed for the use of different treatment pressures as

[2] Here Szmukler and Appelbaum (2008) made reference to the work of Wertheimer (1987) who argued for a moral baseline to distinguish between what constitutes a threat and what constitutes an offer.

one ascends the hierarchy. They conceded however that these definitions may not correspond with how treatment pressures are subjectively experienced by service-users and suggested that subjective accounts are needed within a clinical context. Research into experiences of coercion within the mental health field however is sparse given its wide use.

1.3.3 Other relevant terms

In England and Wales the term 'compulsory treatment' is used when non-adherence to treatment can be responded to with force supported by legal statute. The Mental Health Act (MHA) (1983) governs compulsory treatment in England and Wales which can occur either in hospital or the community. The latter is referred to by the term 'Supervised Community Treatment' (SCT) and is governed by 'Community Treatment Orders' (CTOs). 'Formal' legal status refers to service-users under a section of the MHA (1983), whilst 'informal' legal status refers to those not under a section.

Whilst other terms are used to describe compulsory treatment abroad (e.g. 'involuntary or civil commitment' in the USA), in the literature review that follows, I will use the terms used in England and Wales for clarity, even when the study has been done elsewhere. As Szmukler and Appelbaum (2008) suggested, this study is interested in a broad range of 'treatment pressures'. However since this is not a term widely used in the literature, I shall use the term 'coercion' to parallel the vocabulary of the studies done to date. When terms particular to each study are used they will be explained.

1.4 Coercion beyond psychiatry

I focus the bulk of the following review on the literature found on coercion in psychiatry. Before I begin, it is worth noting that a number of people have discussed the use of coercion in the context of talking therapies. For example Masson (1988) who described psychotherapy as a "confining institution" (p.47) in his discussion of it writes:

> We hear from many patients and former patients how much benefit they have derived from a certain person or treatment...I am not questioning their belief that they have been helped. But a little reflection suggests that it would be difficult for some people to believe otherwise given the indoctrination process they are subjected to both inside and outside institutions (society at large accepts, unthinkingly, psychiatric values). Even when therapy is voluntary, there is an emotional and mental coercion that is rarely examined by members of the professions. When therapy is not voluntary, the opportunities for oppression become even greater (Masson, 1988, p.286-287).

In a similar vein Smail (2003) discussed how the culture of personal change commonly espoused by talking therapies, can easily entail a therapist passing superior judgement about how a person ought to be. Unlike Masson, Smail suggests that the coercive nature of talking therapies can be mitigated by therapists concentrating on issues of social power and change rather than of a personal nature.

I shall focus on coercion within a psychiatric context for the remainder of the literature review.

1.5 Historical context

In this section I will outline the historical context of the rise of the use of treatment pressures in mental health services.

Cromby et al. (2013) describe how injustices within the asylum system have been reported across time in accounts written by recipients of services; and suggested “those considered mad have often suffered harsh treatment in squalid conditions” (p.23). Indeed coercion, and the reaction to it, has been pivotal in the evolution of psychiatric practice and service provision.

1.5.1 The rise of psychiatry and compulsory treatment

Legislation governing the use of compulsory treatment has existed for over two hundred years. Multiple reformations have occurred - in terms of what powers and safeguards it entails - as changing ethical, political, legal and social factors all contribute to our understanding of distress and how we 'treat' it[3]. Over history legislative reforms have illustrated a shift towards an increasingly welfarist approach within mental health services. This presumes it may be necessary to compulsorily detain someone when they are considered to suffer from a mental disorder, in the interests of their own health and safety, or that of others (Barber et al., 2009).

Psychiatry as a profession was borne out of the European Enlightenment and its emphasis on both reason and the individual (Bracken and Thomas, 2001). Porter (1987) proposed that during this period, those considered to be unreasonable or foolish were criticised and condemned in order to preserve a progressive and rational society. Foucault (1971) similarly suggested that the process of institutionalisation during this period was led by social exclusion motives rather than marking scientific or medical progress, and that the psychiatric profession grew directly from this.

Szmukler (2013) described how during the 18th century insanity and detention were synonymous and the treatment of lunacy unregulated. Numbers housed in asylums grew beyond expectation, largely because of industrialisation. The County Asylums Act (1845) required that all asylums with a capacity of over a hundred patients had a doctor living within the asylum, illustrating the idea that distress was in need of medical treatment. Concerns grew about the unjust detention of people, thus the Lunacy Act (1890) required all patients to have a magistrate hearing before they could be detained within an asylum. However, custodial management was increasingly used due to high numbers of inpatients, and abuses were frequently publicised. "Earlier concerns about the protection of the sane from wrongful detention were, over time, joined by concerns about the protection of the insane while detained" (Szmukler, 2013, p.5). Over history we

[3] A full discussion of the historical context of medical conceptualisations is relevant but beyond the scope of this chapter. Please see the work of Scull (1979).

see that scandals concerning abuses subsequently led to increased legislation to protect service-user rights.

1.5.2 Continued patterns of abuses and reform

This pattern continued throughout history. In 1957, prior to the MHA (1959) the Percy Commission suggested that “the law should be altered so that whenever possible suitable care may be provided for mentally disordered patients with no more restriction of liberty or legal formality than is applied to people who need care because of other types of illness, disability or social difficulty” (Percy Commission, 1957, para.7) which again reflected a move towards the protection of service-users. The MHA (1959) - which stated that hospital admission was to be informal unless a patient needed to be detained formally - although first thought of as liberalising legislation, was subsequently considered inadequate in protecting the rights of inpatients following service failures and abuses of power by professionals (Grounds, 2001).

More recently further measures to safeguard rights were therefore brought in by the MHA (1983); which established a Mental Health Act Commission to oversee the treatments of detained patients, introduced controls over the use of certain treatments (e.g. electroconvulsive therapy) and made it a requirement that aftercare be provided (Cromby et al., 2013). The review process pertaining to formal hospitalisation was also tightened up with the introduction of the Mental Health Review Tribunal (Szmukler, 2013).

Cromby et al. (2013) argued that abuses within psychiatric services followed by reforms in the laws governing it have occurred cyclically throughout history. They suggested that by tracking the changes in mental health legislation we can see that, “alongside a history of humane treatment there is a parallel history of neglect, abuse, inquiries and reforming legislation, a pattern which has continued to this present day” (Cromby et al., 2013, p.31).

1.5.3 The antipsychiatry movement

Bracken and Thomas (2001) argued that the modernist focus on reason and the individual has resulted in three consequences: madness is conceptualised as internal; psychiatry continues to promise a technological understanding of distress (i.e. psychopathology and neuroscience); and psychiatry has been granted substantial power in order to coerce and control those considered mad (through incarceration, powerful drugs, ECT and psychosurgery). Proponents of antipsychiatry such as Thomas Szasz (1961) maintained that the psychiatric profession were in the business of diagnosing unwanted behaviours as 'mental illness' and absolving individuals of responsibility for their actions. The antipsychiatry movement also argued that psychiatry was repressive and mental health service-users were in need of liberation.

Bracken and Thomas (2001) suggested that neither psychiatrists nor antipsychiatrists have been successful in their endeavours. Instead they propose that a postpsychiatry is necessary:

> It [postpsychiatry] does not propose new theories about madness, but it opens up spaces in which other perspectives can assume a validity previously denied them. Crucially, it argues that the voices of service users and survivors should now be centre stage (Bracken and Thomas, 2001, p.727).

1.6 Current context

1.6.1 Legal and ethical context

The most obvious use of coercion in current mental health services is the compulsory treatment of service-users under the MHA (1983). This legislation states that a service-user may be detained for assessment and/or treatment, or compulsorily treated in the community, if they are considered to have a mental disorder and at risk of harming themselves or others. This power is unique to mental health services. Under the Mental Capacity Act (2005) people may not be

given treatment without their consent unless they lack the capacity to make the decision[4]. Although the MHA (1983) enables the compulsory treatment of a service-user with the capacity to make treatment decisions who refuses to comply, it should be noted that mental health service-users are often wrongly assumed to lack the capacity to make treatment decisions based on their diagnoses (Chamberlin, 1997).

The MHA (1983) contains safeguards for the use of different compulsory treatments. For example medication cannot be compulsorily given beyond three months and electroconvulsive therapy (ECT) cannot be commenced without the service-user's consent or the agreement of a second medical opinion. Psychosurgery cannot take place without both the service-user's consent and the agreement of a second medical opinion. This variation in the permissibility of different treatments perhaps reflects the different societal views or controversies about them.

Richardson (2008) suggested that the mere existence of the MHA (1983) and the blatant power differences between service-users and professionals serves to create pressure to comply with treatments proposed by mental health services. Thus service-users' experiences of coercion are not limited to times when the MHA (1983) is invoked. 'Voluntary' consent amongst informal service-users must therefore be treated with caution. In her discussion of human rights law concerning protection of a person from undue coercion Richardson stated that the European Court of Human Rights (ECRH), "currently fails to capture much of the coercion experienced by patients in practice…it might be argued that the threshold of illegality currently set by the ECRH is too high as it legitimizes the use of too much coercion" (2008, p.252).

The emphasis of the 2007 amendments to the MHA (1983) was 'public protection' as a result of fears that 'community care had failed'. The legislation therefore largely concerns provisions for formal psychiatric treatment outside of the hospital. The Report of the Expert Committee (Department of Health (DoH), 1999) – headed up by the lawyer, Genevra Richardson - was written to advise on

[4] Except in very restricted circumstances; for example if someone has an infectious disease that could kill others.

these reforms. This report provided a framework for the use of compulsory treatment and contained key ethical principles to set the tone of the revised legislation and guide its interpretation. The ethical principles included:

Patient autonomy

This refers to “respect for the treatment choices of those who have the capacity necessary to make them” (DoH, 1999, p.18).

Principle of reciprocity

When someone is compulsorily treated there should be a parallel obligation on health and social services to provide appropriate care.

Principle of provision of information

Service-users should be provided with the necessary information in order to enable them to fully participate in their care.

Many of the suggested principles support the use of ‘procedural justice’ during the process of compulsory treatment. Procedural justice refers to how fair the processes of making and implementing decisions are (Maiese, 2004), a concept discussed in more detail in section 1.9.

Grounds (2001) discussed how many of the ethical principles proposed by the Expert Committee (DoH, 1999) were either diluted or removed in the Green and White Papers that preceded the MHA amendments in 2007. He described how the legislation became harsher and less balanced, liberal and principled. He stated that the removal of the principle of reciprocity “ignores the need to elevate care provision to the realm of human rights” (Grounds, 2001, p.387). It seems that despite recommendations, the amended 2007 MHA maintains a context in which coercive measures can occur without the suggested safeguards. Perhaps this indicates that we are in another cycle of legislation reform followed by abuse described by Cromby et al. (2013).

‘Autonomy’ was one of the key principles outlined in the report by the Expert Committee (DoH, 1999). Freyenhagen and O’Shea (2013) discussed this concept and suggested that current accounts either fail as criteria of autonomy, or are not normatively neutral as they encompass cultural values and norms. They argued that ‘normatively-neutral’ accounts of autonomy (that is, those that do not attend to the substantive content of beliefs or values) fail to adequately capture the lack of autonomy, for example in service-users with a diagnosis of ‘anorexia nervosa’. Similarly, the assumption of irrationality inherent to the diagnosis of ‘schizophrenia’ (by virtue of diagnostic criteria that include the experience of ‘delusions’ and/or ‘hallucinations’), precludes any notion of capacity and therefore autonomy, based on subjective ideas about what is ‘normal’ or ‘abnormal’ behaviour as laid out in diagnostic manuals such as the Diagnostic and Statistical Manual (American Psychiatric Association).

They instead suggest “not without controversy - that capacity assessment, based on norms not shared by the assessed person, and leading to restriction of liberty, is sometimes necessary; but the harms of these interventions can be lessened by being shaped by those who have experienced being subject to them” (Freyenhagen and O’Shea, 2013, p.67). Thus they proposed it is necessary to engage with service-users’ beliefs and values and their experiences of services in order to act ethically when treatment pressures are employed. They also warned against the overuse of coercion because of its misuse in the past; “historically informed caution concerning the harms of abuse (rather than respect for autonomy per se) speaks in favour of a very high threshold for non-consensual intervention even when mental capacity is found to be lacking” (Freyenhagen and O’Shea, 2013, p.67-68). However based on statistics about the use of compulsory treatments it seems that the threshold for their use is being lowered rather than raised. In the following section of this chapter I will consider some of the driving forces behind this increase.

1.6.2 Increasing use of coercion

> There has been an upward trend in the use of compulsory treatment since the 1980s (Cromby et al., 2013, p.171).

Statistics from the DoH Information Centre show that the number of compulsory admissions has doubled since 1987 (it went up by 70% between 1987 and 1997). The Mental Health Act Annual Report 2011/12 written by the Care Quality Commission reported that there was a 5% increase in the number of detentions and a 10% increase in the number of CTOs in 2012. They also noted that many informal service-users were unable to leave locked wards for fear of being sectioned and one third of community service-users are subject to informal threats regarding their housing, benefits or rights to care for their child.

Critics have suggested that the increased use of coercion in community mental health services has been driven by portrayals in the media about misconceptions about increased risk and of service-users as dangerous (Szmukler, 2008) and the political context in which the interface between services and their users is governed (Davidson and Campbell, 2007; Hannigan and Cutcliffe, 2002).

To illustrate this point; interest in the newly 'discovered' diagnostic category, 'dangerous people with severe personality disorder' mounted following a few high profile homicide cases in the 1990s. At the time legislation changes meant that personality disorder was 'no longer a diagnosis of exclusion' and people with these diagnoses could be compulsorily treated under the MHA (1983). Although both legal and medical bases for the diagnosis were lacking, 'Managing Dangerous People with Severe Personality Disorder' (a DoH consultation paper) was released (Mullen, 1999).

Hannigan and Cutcliffe (2002) argued that the power professionals can exercise in certain circumstances to compel service-users into treatment reflects the paternalism inherent in current mental health services; illustrated by contemporary discourses about those with mental health problems as 'different' and in need of management or control.

In order to illustrate the rise of coercive practices in mental health services I will now consider prevalence rates of coercion: how these are identified in the literature; studies of both inpatients and outpatients; and why I feel the methodologies of identifying them are flawed.

1.7 Prevalence rates

1.7.1 Rates of coercive measures

Salize and Dressing (2004) investigated the use of compulsory hospitalisation and treatment across the European Union and found that rates differed vastly in terms of use (a 30-fold difference between Portugal and Finland), rules, regulations and strategies. They proposed this reflects variations in legal frameworks and procedures. They also described how data on compulsory hospitalisation and treatment is scarce and highlighted the need for overviews regarding this controversial area of mental health care. This study highlighted the need to gather more reliable data on the employment of coercive measures.

Other researchers have collected data on the rates of different types of coercive measures experienced by service-users after the process of admission to a psychiatric ward using self-report measures, and found that reports of various methods of coercion are common (Sørgaad, 2007). Kjellin et al. (2004) carried out structured interviews with psychiatric inpatients in Sweden. They reported that 63% of formal service-users had been exposed to measures against their will; 73% had been denied leaving the ward; 48% had been exposed to forced medication; 16% had been restrained by belt; and 6% had been secluded. They also assessed rates of the use of these measures amongst informal service-users, and reported that 20% had been exposed to measures against their own will; 40% had been denied leave from the ward; 3% had been exposed to forced medication; 0% had been restrained by belt; and 1% had been secluded. These results indicated that coercion in psychiatric care as defined by service-users was not always legally based, and a substantial number of both formal and informal service-users experienced coercive measures. The authors also reported that a considerable proportion of service-users felt that their integrity was violated during the admission process.

The type and number of coercive experiences have been reported to affect the overall ratings of coercion reported by service-users. For example; the number of

forceful, threatening or persuasive experiences has been reported to be a key feature of whether a hospitalisation feels coercive or not (Monahan et al., 1995); depot antipsychotic medication has been reported to be associated with higher levels of perceived coercion than oral antipsychotic medication (Patel et al., 2010); and unlocked wards have been reported to reduce the perceived coercion regarding the admission process for formal service-users (Kjellin et al., 2004).

Research has shown that the rates of treatment pressures amongst outpatients are also high. For example Monahan et al. (2005) reported that 44-59% of outpatients had experienced at least one form of explicit leverage; where leverage is the use of informal power such as the offer/withholding of goods or services for compliance/noncompliance e.g. money, housing or access to one's children. Burns et al. (2011) reported that 35% of community patients in Oxford had experienced leverage.

Although it is important to gather data on rates of the use of coercive measures beyond the use of compulsory treatment under the MHA (1983), quantitative studies such as these do not enable us to explore the whole range of measures service-users experience as coercive (as the structured interviews and measures reported are defined by researchers), nor do they elaborate on why these experiences feel coercive or violating. I will now go on to discuss studies that have sought to employ quantitative methods to explore service-users' experiences of coercion

1.7.2 Measures of perceived coercion

A substantial number of studies identified in the literature used measures of perceived coercion to assess the prevalence of coercive experiences for service-users. The most commonly used quantitative measure was the Perceived Coercion Scale (PCS) which was derived from the MacArthur Admission Experience Interview (Gardner et al., 1993), originally developed to assess levels of perceived coercion during hospital admission. It has since been applied to a number of different research groups and has been adapted for use in different settings, such as community mental health services (Davidson and Campbell, 2007). The PCS provides a single index score of coercion based on five items.

Participants are presented with five statements regarding: perceived freedom, choice, control, and influence over using mental health services; and are asked to answer them in a true/false format. All of the PCS items have been reported to bear high loadings on the perceived coercion dimension and respondents have been said to respond to the questions in a consistent way (Gardner et al., 1993). Although promising, these results are not proof of the measure's validity (Høyer et al., 2002).

Høyer et al. (2002) developed the Coercion Ladder (CL) which is a visual analogue scale, and again was designed to assess levels of perceived coercion at admission to hospital. It is a single measure of coercion and asks participants to say which step on the CL (where 1 is minimum use of coercion, and 10 is maximum use of coercion) best corresponds with the amount of pressure they experienced from others when admitted.

1.7.3 Perceived coercion: Overall prevalence rates

A recent review by Newton-Howes and Stanley (2012) of eighteen studies (sixteen inpatient, two outpatient populations) reported that the raw combined prevalence rate of perceived coercion amongst psychiatric service-users was 53% (ranging from 22% to 87%). Legal status was found to be strongly associated with perceived coercion: the raw combined prevalence rate of coercion for the legally detained group of service-users was 74%, whilst it was 25% for the informal group. The use of meta-analysis in this study is questionable, as rates of perceived coercion could be significantly affected by place and time. However, despite the large variations in the contexts of the samples considered, this review nonetheless indicated that perceived coercion was commonly experienced, even amongst those who are not under a legal section and received treatments they have supposedly consented to. The authors also reported that studies which assessed levels of coercion with the CL measure reported lower levels of coercion than those who used the PCS. This suggests that variations in questioning about the experience of coercion will impact on how people respond. This issue will be discussed in more detail in section 1.7.6.

1.7.4 Perceived coercion: Inpatient studies

Within research focused on inpatient care, rates of perceived coercion appear to be high, regardless of legal status (Bindman et al., 2005; Cascardi and Poythress, 1997; Katsakou et al., 2011). For example, Sheehan and Burns (2011) found that 47% of informal service-users and 89% of formal service-users reported high[5] levels of coercion.

39% of informal service-users felt that if they hadn't 'volunteered' to go into hospital they would have been sectioned (Monahan et al., 1996) which supports the suggestion that the very existence of the MHA (1983) serves as leverage for informal service-users to comply (Richardson, 2008). Research has also reported that many service-users are confused with regards to their legal status (Sørgaad, 2007) and what this means in terms of what they are able to do/restricted from doing, such as leaving the ward (Bindman et al., 2005). These findings perhaps accurately reflect the change of service-user status whilst on the ward and/or a lack of clear information provision.

1.7.5 Perceived coercion: Outpatient studies

Yeeles et al. (2011) reported that over one third of service-users in community mental health care felt that coercion was part of the care they received from clinicians. Davidson and Campbell (2007) used the PCS and reported that levels of perceived coercion were high amongst service-users receiving Assertive Community Treatment (ACT) although after 18 months these lessened and were equivalent to service-users accessing Community Mental Health Treatment. The authors suggested that these initial differences in baseline measures reflected the different strategies used to engage service-users within these two treatment models (ACT involves a high level of contact initially). From this they concluded that "coercion is an everyday aspect of community mental health" (p.550). In contrast Appelbaum and Le Melle (2008) found little evidence for high levels of perceived coercion amongst service-users accessing ACT. This raises an interesting question regarding causes of such variance within the research

[5] This was defined as a score of three or more out of five on the PCS.

literature. I suggest that such variation is an artefact of the measures used: a problem that undermines the reliability[6] and validity[7] of such 'standardised' measures and calls for a different approach.

1.7.6 Flaws inherent in this type of research

> We should adapt our methods so far as we can to the object and not define the object in terms of our faulty methods (Allport, 1963, p.28).

Whilst quantitative self-report measures such as the PCS (Gardner et al., 1993) and the CL (Høyer et al., 2002) are useful to ascertain what percentage of large populations report experiencing coercion, and to make statistical comparisons between different groups, they are not without fault. Their use reflects a non-critical acceptance of the scientific method as their proponents assume we can reliably measure service-users' experiences of coercion. However as Kazdin (2006) stated, "many facets of a measure, such as the number of response alternatives for individual items, the anchors or endpoints of the scale for the items, and the order in which the items appear, can influence a person's scores on individual items and on the scale overall" (p.44).

The rigid structure and inflexibility of self-report measures mean that they restrict what participants say and therefore limit our understandings of the phenomenon being investigated. Measures such as the PCS and the CL are written by researchers and do not allow participants to use their own words to portray and describe their subjective experiences of coercion. The structure of measures does not allow respondents to qualify their answers (Walonick, 1993); participants are unable to explain why they have picked the response they have, nor can they tell the researcher experiences that relate to particular items. These methods are similarly unable to capture multiple or contradicting views a service-user may hold. For example one item on the PCS (Gardner et al., 1993) states 'I had a lot of control over whether I went into hospital' - limiting the respondent to answer this question as only either true or false, prevents them from explaining

[6] 'Reliability' refers to the extent that these measures are consistent, irrespective of context.
[7] 'Validity' refers to the usefulness of these measures; whether they actually measure 'coercion' and whether constructs such as 'lack of autonomy' make sense to the overall concept.

which aspects of the process they felt they had more or less control over and why; thus it neglects much of what is interesting in service-users' experiences of coercion. Similarly self-report measures are only able to capture one moment in time, and although they can be repeated they are unable to portray the subtleties of changes in respondents' experiences of coercion over the course of time. What score on a measure delineates 'perceived coercion' from 'no perceived coercion' is also an arbitrary limit, again decided by the researcher rather than the participant.

Further issues of the validity of self-report measures are raised by research findings that suggest people sometimes respond to items in ways that are not directly related to what they are being asked about (Bradburn, 1983). For example, studies which adopt a structured interview method of gathering data rather than a written questionnaire are subject to interviewer bias. Respondents may have felt unable to express their experiences of coercion to someone who they perceived to be in authority, especially when sets of data were collected whilst respondents were still on the ward (as in e.g. Katsakou et al., 2011). A large number of studies have also reported that the wording of questions can significantly impact on how people respond to them (Schuman and Presser, 1981). Further issues of ecological validity (how artificial a measure is in comparison to the 'real' world) are raised by Cicourel who states, "the theoretical foundations of interviews and surveys also must address the way that artificial circumstances often violate ecological validity, or the way interviews and survey questions are constructed, understood, and answered" (Cicourel, 1982, p.11).

Overall self-report measures of perceived coercion, despite their advantages in capturing the experiences of large groups of people, lack depth in their examination of service-users' experiences as they fail to capture their complexity or richness and are predominantly defined from the researcher's perspective rather than the participant's.

Since there appear to be more facets underlying the construct of coercion than traditional quantitative methods allow, I now turn my attention to the relationship

between coercion and service-user characteristics, as an important feature in findings about rates of coercion.

1.8 Relationship between coercion and service-user characteristics

1.8.1 Gender and Age

Katsakou et al. (2011) reported that gender was marginally associated with levels of perceived coercion amongst informal inpatients hospitalised service-users, with 40% of women and 29% of men scoring three or more on the PCS (Gardner et al., 1993). Another study considered the experiences of SCT and the use of social welfare leverage (e.g. the receipt of benefits depending on medication compliance) and reported that male gender and younger age were independently associated with both (Swanson et al., 2006). Bindman et al. (2005) contrastingly found that older age was associated with higher levels of perceived coercion. Age has also been found to be associated with service-users' views about the use of coercion, with one study finding that older service-users expressed less disapproval for the use of these types of measures (Whittington et al., 2009).

1.8.2 Ethnicity

It has been reported that those from a minority ethnic group are more likely to receive compulsory treatment than their white British counterparts (Care Quality Commission, 2012). Similarly a review by Bhui et al. (2003) reported that black people are more often treated as inpatients and four times more likely to be subjected to compulsory treatments than their white counterparts. Other studies have shown that non-white ethnicity is associated with higher levels of perceived coercion in both inpatient (Bindman et al., 2005) and outpatient populations (Swartz et al., 2002).

The *Count Me In* census (Care Quality Commission, 2010) suggested that rates of coercion are higher for black people in some parts of mental health services. The census reported that psychiatric admission rates remain higher than average for some minority ethnic groups, particularly black/white mixed groups, and black

mixed groups. Similarly rates of detention under the MHA (1983) are higher than average amongst black, white/black Caribbean mixed and other white groups. Rates of detained service-users who were placed on a CTO are higher among south Asian and black groups. The census also suggested that although seclusion rates have fluctuated, rates of the use of this coercive method have been higher than average for black, white/black mixed and other white groups. Black people are also more likely than white people to be referred into mental health services from the criminal justice system (DoH, 2003).

Some have suggested biological explanations for these findings whilst others have looked for social explanations. The Race Equality Foundation (2007) argued that men from African and Caribbean backgrounds are over-represented in mental health services and are more likely to receive harsher, more coercive treatment (e.g. sectioning, seclusion, control and restraint) as they have negative views of mental health services and therefore enter them via the police and the criminal justice system. They also suggested that black males more often find themselves in situations that put them at greater risk of mental health problems (such as racial victimisation, social deprivation, exclusion from schools and crime and drug cultures) and conclude that more research is needed to understand the links between race, racism and mental health. The chair of the Care Quality Commission similarly highlighted the need to progress from counting numbers of service-users in terms of ethnicity, to understanding more fully the factors leading to hospital admission, such as the socio-economic and other disadvantages faced by black and minority ethnic communities and the routes through which some ethnic groups enter the mental health system.

The Mental Health and Crime Briefing produced by Nacro (2007) proposed that, “Racism, cultural ignorance and stereotypical views can often combine with the stigma and anxiety associated with mental illness to undermine the ways in which mental health services respond to black communities, affecting decisions about treatment, medication and restriction” (p. 3-4). Bindman et al. (2005) suggested that those who experience poverty and social exclusion may be more likely to perceive coercion and these factors should be taken into consideration and explored further. “Greater insight into the ways that race influences the client’s

response to coercive treatment circumstances may assist the provider to reshape clinical encounters to foster greater acceptability of services for minority consumers" (Galon et al., 2012, p.212). The existing literature on the processes involved for black and minority ethnic groups and the experience of treatment pressures is sparse. Perhaps exploratory qualitative methods are better suited to developing our understanding of the complex relationship between ethnicity and the experience of treatment pressures.

In the next section of this chapter I will consider the role of procedural justice in mental health service-users' experiences of coercion.

1.9 Procedural justice

Procedural justice refers to how fair the processes of making and implementing decisions are. Given that mental health service-users' experiences of coercion are predominantly related to treatment decisions, researchers have attended to the relationship between coercion and procedural justice. Maiese (2004) suggested that what makes these procedures fair includes: the person for whom the decision applies having their views heard and represented in the decision-making process; and their believing the intentions of other people involved in the procedures are fair, benevolent and trustworthy.

A number of studies have found evidence to support the hypothesis that procedural justice plays a significant role in whether hospital admission or treatment feels coercive (Cascardi and Poythress, 1997; Monahan et al., 1995); how satisfied service-users are with the treatment they receive (Kallert et al., 2007); and how they subjectively rate its outcome (Wallsten et al., 2006). For example Hoge et al. (1997) found that levels of perceived coercion were related to levels of perceived procedural justice, as measured by the Procedural Justice Scale (Lidz et al., 1995). Levels of perceived coercion during hospital admission have also been reported to be associated with service-user participation in decision-making; whether deceit was used; and whether the service-user felt respected (Bennett et al., 1993) or listened to by clinicians (Hoge et al., 1993).

The vast majority of these studies employed quantitative self-report measures in their exploration of procedural justice and experiences of coercion, and so are therefore subject to the same criticisms outlined in section 1.7.6.

In a review of quantitative studies on experiences of coercion amongst inpatients, Katsakou and Priebe (2006) reported that service-users viewed their compulsory hospital admission as positive when asked retrospectively, though a significant proportion continued to feel that the admission was neither beneficial nor justified. More recently Priebe et al. (2009) reported that 60% of inpatients said their compulsory admission was unjustified one year later.

Swartz et al. (2004) explored service-users' perceptions of fairness with regards to compulsory community treatment and reported that 55% thought it was fair. The authors went on to describe how service-users who made use of a biopsychosocial model to understand their distress (i.e. thought of themselves as unwell and in need of treatment) were more likely to report that the compulsory treatment was fair. They suggested that this was because they felt the treatments provided, and the associated coercive experiences, were done in their best interests and out of concern for their well-being. This study suggests that the ways in which service-users make sense of their distress can impact on their perceptions of procedural justice and therefore possibly their subjective experiences of coercion also. The study assigned participants to a 'medical model view' group or 'non-medical model view' based on their answers to vignettes in which respondents had to rate on a Likert-type scale the likelihood that a person's situation was attributable to bad character, upbringing, God's will, a chemical imbalance in the brain, genetics or stress; the first three of which were taken to indicate endorsement of a nonmedical view whilst the latter three were assumed to indicate endorsement of a medical view. This raises an interesting ethical debate about whether the use of a medical 'illness' model *per se*, in the absence of consistent research regarding the reliability and validity of 'mental disorders' as outlined in the DSM, should in itself be considered a coercive treatment pressure. However as it is, this seems to be a gross simplification of how people make sense of their experiences of distress and how this in turn

impacts on their experiences of treatment and treatment pressures, which exploratory qualitative methods would be far more suited to examine.

As Maiese (2004) noted in her analysis, the relationships one has with others involved in the decision-making process play an important role in the experience of procedural justice. People find it easier to accept an outcome, even ones they do not like, when the procedures involved in the decision-making process entail treating them with respect and dignity (Deutsch, 2000). Accordingly a number of studies into service-users' experiences of coercion have investigated relationships between service-users and clinicians - who often play a role in treatment decisions. I will now focus my attention on these findings.

1.9.1 Experiences of coercion in the context of relationships

> Perceived coercion has a variety of determinants, many of which are dependent on the quality of the relationship with the clinician (Newton-Howes and Mullen, 2011, p.470).

Sheehan and Burns (2011) explored the association between perceived coercion and the service-user - clinician relationship, using self-report measures. They reported that high levels of perceived coercion were associated with a poor rating of the therapeutic relationship. The use of quantitative measures to rate both perceived coercion and the therapeutic relationship in this study precludes us from understanding more about the processes that mediate and influence the interaction between the therapeutic relationship and the experience of coercion. Qualitative studies have explored these issues further.

In a qualitative study of the experience of psychiatric hospital admission Gilburt, Rose and Slade (2008) reported that experiences of coercion, which were often associated with feelings of a lack of safety rather than actual coercive acts (e.g. restraint), were the main obstacle in forming a therapeutic relationship with clinicians. The findings suggested that when the staff member enacting the MHA (1983) was able to instil a sense of safety during the process, it was perceived as a more positive experience. The authors' therefore concluded that the experience of coercion was a function of the therapeutic relationship, not just mental health

legislation. This perhaps indicates that coercive practices result from the inherent power imbalance between clinicians and service-users, when one of the clinicians' primary tasks is to exert 'control' over service-users.

Katsakou and Priebe (2007) carried out a review of qualitative studies and reported that compulsory hospitalisation and treatment involved both positive and negative aspects. Positive aspects included being involved in treatment decisions, feeling cared for rather than coerced, and being treated as an ordinary human being. Close relationships were reported to alleviate service-users' experiences of uncertainty and fear when compulsorily admitted to hospital. In the context of these supportive networks participants seemed to find it easier to justify and accept compulsory treatment. A more recent systematic review of qualitative inpatient studies however, reported that coercive experiences were linked to a feeling of violation of integrity; not being respected; not being heard by clinicians; as well as dehumanisation through isolation and a loss of 'normal' human interaction (Newton-Howes and Mullen, 2011).

This research provides much support for the idea that the therapeutic relationship is vitally important in service-users' experiences of coercion and the qualitative methods used supply rich data. However, the focus on hospital admission and compulsory treatment fails to capture many other experiences that service-users might define as coercive.

One study explored outpatients' experiences of coercion in ACT. Thorgersen, Morthorst and Nordentoft (2010) reported that a poor alliance with their case-manager; not being recognised as an autonomous person; and experience of staff intruding on their privacy were central to service-user perceptions of coercion. A collaborative and mutually trusting relationship with their case-manager, as well as the availability and commitment of staff, were important in offsetting these experiences. In a review of recent studies that have examined the use of compulsory treatments both in hospital and in the community, Sheehan (2009) noted that the therapeutic relationship was recognised as an important factor in alleviating the distress that coercive measures cause. Possible processes through which this could be achieved however were not elaborated

upon. Overall these studies lack a broad perspective on the whole range of treatment pressures experienced by service-users and a detailed understanding of them in a variety of different contexts.

Having considered one aspect of procedural justice – the relationship with the person involved in the decision-making; I will now turn my attention to another element of procedural justice – the involvement of service-users in decisions concerning their treatment.

1.9.2 Involvement in the decision-making process

Procedural justice necessitates the involvement of service-users in decisions concerning their treatment. This in turn entails their provision with enough information in order to have informed opinions of the treatment options, and that their views are listened to. Given this, some of the identified research has explored the relationship between service-users' involvement in treatment decisions and their experiences of coercion, and the role of information provision in this process.

A mixed methods study of informal inpatients reported that service-users' lack of sufficient participation in the admission and treatment process was significant in their experiences of coercion, as was not feeling cared for or respected by staff (Katsakou et al., 2011). Similarly the findings of a qualitative study of outpatient treatment suggested that having influence over the treatment decision process was a central component in whether ACT felt coercive or not (Thorgersen, Morthorst and Nordentoft, 2010). Helplessness was reported to hinder service-users' desire to play an active role in their treatment decisions by Laugharne et al. (2012). The authors argued that threats of coercion and neglect disable service-users.

Several researchers have suggested ways to improve treatment decision processes. Both Kaltiala-Heino et. al (1997) and Monahan et al. (1996) argued that making the process of treatment more transparent through involving service-users in decisions and humanising the process, can result in better outcomes even when it is necessary to use coercive interventions. A study in the USA

reported that completion of an advanced directive was significantly associated with fewer coercive crisis interventions (Swanson et al., 2008). The authors suggested that writing advanced directives enabled service-users to become more engaged with their treatments, improved the working alliance through the process of writing them, reduced the need to invoke mental health law, and gave service-users a voice and a potential experience of feeling respected by clinicians. Similarly Henderson et al. (2009) found evidence supporting the hypothesis that when joint crisis plans are written, service-users feel empowered and more in control of their mental health problems.

1.9.3 Information provision

The provision of adequate information regarding treatments is necessary if service-users are to fully participate in treatment decisions (as was suggested by the Expert Committee, DoH, 1999). Research findings that indicate service-users' lack of information with regards to legal status and whether they are free to leave the ward or not (discussed in 1.7.4), highlight problems in the process through which information is provided. Johnsen et al. (2007) suggested that service-users' exclusion from decisions can be minimised through better provision of information regarding their legal rights. Indeed psychiatric service-users have expressed a strong desire to be given more information; orientation to what's happening to them and why; communication; and respect (Sibitz et al., 2011).

In a literature review concerning experiences of coercion, the provision of information and informed consent in relation to ECT, Rose et al. (2005) reported that approximately half of the participants said they had not received sufficient information about ECT and its side-effects; and around one third felt that they hadn't freely consented to the treatment even though they had signed a consent form. In the case of ECT, this raises the question of *what* information is provided in order for a service-user to make 'informed consent' given that current medical explanations for its apparent effectiveness provide little 'explanation' at all.

The research investigating procedural justice illustrates the importance of the therapeutic relationship, involvement in treatment decisions and the provision of adequate information in service-users' experiences of coercion. However, further

elaboration of the processes involved and exploration of these issues in different contexts is needed.

So far I have outlined the literature that has attempted to define and quantify the experience of perceived coercion in a variety of mental health settings and the facets important to this construct. I will now go on to consider the different types of impact treatment pressures can have on the lives of those subjected to them.

1.10 Impact of treatment pressures

A number of studies identified in the literature search explored the impact of experiences of coercion on both the service-user as an individual and within a wider context.

1.10.1 A traumatic experience

Tekkas and Bilgin (2010) reported that containment methods used in psychiatric wards (such as forced medication, physical restraint and seclusion) can result in both physical and psychological damage to the service-user whilst also serving as effective management strategies. Some researchers have sought to elaborate on the psychological impact of coercive experiences and suggest that compulsory admission and treatment increases service-users' feelings of fear, sense of victimisation and helplessness with regards to their experiences (Beveridge, 1998; Brody, 1995; Rooney et al., 1996). A more recent review by Katsakou and Priebe (2007) reported that coercive interventions in an inpatient context have been described by service-users as a violation of their autonomy, an attack on their ability to self-regulate, and led to feelings of powerlessness and failure.

These findings help us to understand the results reported by Tony Morrison et al. (1999) who examined the psychological impact of admission to psychiatric hospital and found that in a sample of 34 service-users, the majority reported experiencing strong and varying emotional reactions and 44% had clinically significant levels of post-traumatic stress disorder symptoms, as measured by the

Impact of Events Scale (Horowitz, Wilner, and Alvarez, 1979). Priebe, Broker, and Gunkel (1998) found a similar rate of post-traumatic stress disorder symptoms (51%) following treatment experiences amongst outpatients diagnosed with 'schizophrenia'. As these studies used self-report measures they enable us to investigate the prevalence of trauma responses but do not elucidate how or why service-users might experience compulsory treatments as traumatic. Their focus on compulsory treatment also precludes a wide range of other potentially coercive experiences.

1.10.2 Other emotional reactions and the wider impact of coercion

Other literature indicates alternate emotional reactions to experiences of coercion. Increased levels of perceived coercion have been reported to have a negative impact on self-identity (Trochim et al., 1993); and have a negative impact on quality of life and lead to lowered self-esteem (Link et al., 2008). Qualitative studies have reported that experiences of coercion amongst inpatients have led to feelings of loss of competence (Hughes, Hayward and Finlay, 2009); feelings of sadness, depression and humiliation (Kuosmanen et al., 2007); and contribute to a feeling of helplessness, a loss of confidence and a feeling of anger at being neglected once living back in the community (Laugharne et al., 2012).

Far fewer studies have considered outpatient experiences of coercion; those that have been done however indicate similar findings to those of inpatient studies. For example it has been reported that "becoming a patient" encompassed a loss of credible identity and a loss of autonomy (Gault, 2009); ACT has been described as an attack on identity (Watts and Priebe, 2002); and levels of perceived coercion have been reported to be negatively associated with quality of life and sense of empowerment (Tschopp, Berven and Chan, 2011).

A recent qualitative study by Sibitz et al. (2011) looked at service-users' narratives of compulsory hospitalisation and treatment, and reported that people expressed a range of perspectives. Many participants recognised the need for compulsory treatment when real danger was posed towards themselves or others, but were critical of how coercive measures were implemented, describing them as an "unnecessary overreaction" or "a practice in need of improvement".

The authors also reported that experiences of compulsory treatment made it harder for service-users to trust others, especially doctors; with some subsequently avoiding services. The authors reported that participants described three different styles of integrating the experiences of compulsory treatment into their life narratives: “over, not to be recalled” - in which participants regarded the event as a one-off experience never to be repeated; “a life-changing experience” - where negative impacts on identity, relationships and health were perceived; and “motivation for political engagement” - in which the experience of compulsory treatment provoked people to engage with others and seek reform of the current mental health law. This study provided rich data with regards to service-users’ experiences of compulsory hospitalisation and treatment and its long-term effects, which the authors argued need to be integrated into service development to ensure improvements are made.

Other researchers have also studied the effect of experiencing coercion on future help-seeking behaviours. One study reported that perceived coercion is not associated with subsequent poor engagement with services (Bindman et al., 2005); whilst others have reported that service-users are more likely to avoid accessing/engaging with services they perceived to be intrusive, controlling and coercive (Curtis and Diamond, 1997; Monahan et al. 1995; O’Donoghue et al., 2011; Trochim et al., 1993). Swartz et al. (2003) reported that 36% of services-users said that fear of coercion made them hesitant about seeking help in the future; and the authors concluded that compulsory measures “may serve as a barrier to treatment, but ongoing informal pressures to adhere to treatment may also be important barriers to treatment” (p.460). They highlighted the need to explore the whole range of treatment pressures service-users may experience, not just compulsory treatments.

The research outlined in this section suggests that the experience of treatment pressure can have a significant impact on service-users. Thus it seems ethically important to gain further understanding of the experiences of treatment pressures within all mental health service contexts, and find ways of reducing recourse to coercive measures or ameliorating their negative effects.

1.11 Literature summary

Review of the existing literature indicates that psychiatric service-users commonly experience treatment pressure. As outlined this has been reported in studies of the rates of both compulsory hospitalisation/treatment and other coercive measures (e.g. restraint); studies of perceived coercion as assessed by self-report measures; and also qualitative studies. The literature review indicates a greater number of quantitative over qualitative studies. Whilst quantitative research is useful in exploring the frequency of experiences of coercion, it does not enable service-users to voice, in their own terms, what they feel is coercive and why. There has also been a bias towards investigating (often compulsory) hospital admission and treatment at the expense of finding out about the wide range of experiences that potentially feel like treatment pressures. Similarly little research has explored the effects of treatment pressures over time, or the processes that lead up to these experiences. Further elaboration of the processes involved in the whole range of treatment pressures, and exploration of these issues in different contexts, is essential to the development of a more ethical psychiatric service provision.

1.12 Proposed study

This study seeks to contribute to and broaden some of the areas more sparsely researched in the existing literature. It will employ a qualitative method to explore how a range of treatment pressures are experienced in different contexts; the processes surrounding them; and their impact on service-users' lives.

This study will use a thematic analysis to explore participants' experiences of treatment pressures.

Clinically it is important to understand how service-users experience all types of pressures with regards to their treatment and the processes through which these are enabled or enacted. Thus mental health services can be adapted to reduce their frequency or ameliorate the potential negative effects of their use. Studies

that inform our understandings of the subjective experiences of treatment pressure are therefore essential for ethical practice.

1.13 Research questions

- What range of treatment pressures do service-users experience?
- What are the effects of experiencing treatment pressures on service-users?
- What processes mediate the experience of treatment pressures and how are they managed?

Chapter 2: Methodology

2.1 Overview of chapter

In this chapter I explain my choice to adopt a qualitative methodology in this research and more specifically a thematic analysis method. I also clarify how this relates to the epistemological position I have taken. I outline the procedures of obtaining ethical approval; recruitment; data generation and analysis; and provide information regarding participant characteristics. Issues regarding the assessment of the quality of this research will also be introduced.

2.2 Rationale for using a qualitative method

“Qualitative research is concerned with meaning in context” (Willig, 2008, p.149), and in so being attempts to explore, understand and portray the experiences and actions of people - aiming to create rich understandings of the phenomenon of interest through attention to the perspectives of the people being studied (Elliott et al., 1999).

The existing literature pertaining to mental health service-users’ experiences of treatment pressures was outlined and critiqued in the previous chapter. This study aims to consider aspects that have lacked exploration in the existing body of literature, by adopting a qualitative method to investigate a range of experiences that mental health service-users describe as treatment pressures, and the processes that surround them.

2.3 Epistemological position

Epistemology is concerned with how we can know what we know and whether or not our knowledge is reliable (Harper and Thompson, 2012). It is useful to explain what kind of knowledge this study intended to generate. The research questions were provided at the end of the introduction chapter, in summary they concerned:

how mental health service-users experience treatment pressures; the effects of these experiences; and the processes surrounding them. Thus this study sought to explore the subjective experience of the participants, rather than discover objective truths.

There is much debate and disagreement about how our understanding of the world can approximate some truth about it. Theories range from naïve realism (or positivism) which states there are objective truths about the nature of the world that we can access directly and impartially; to social constructionism, which advocates that human experience and our perception of it, is mediated by the historical and cultural context and the language used to describe it, and therefore suggests that there are a multitude of truths and knowledges (Willig, 2008). It is the responsibility of all qualitative researchers to clearly state their epistemological position, conduct their research using a method compatible with that position and present their findings in a way that is conducive to their appropriate evaluation (Madill et al., 2000). This enables the reader to make sense of the findings (Harper and Thompson, 2012).

A range of different epistemological positions can be adopted when conducting a thematic analysis: realist; contextual constructionist; and constructionist (Braun and Clarke, 2006). A qualitative realist stance proposes research that *discovers* what peoples' experiences are like. Contextual constructionist research assumes that knowledges are necessarily context- and standpoint- dependent, meaning that multiple perspectives about one phenomenon will generate different insights into it. Studies that adopt a constructionist (or relativist) epistemology contest the idea that language is representative of experience; rather all knowledge is seen as created rather than discovered (Schwandt, 2003).

It is important for me as the researcher, to demonstrate 'epistemological reflexivity' by considering how this study has been influenced by the assumptions of the approach I have taken (Willig, 2008). In this research I have adopted a contextual constructionist epistemological stance. I hold the idea that there are such things as treatment pressures, coercive acts and experiences, but what defines these as such will vary amongst different people and contexts. I also

recognise that as the researcher I play an active role in the creation of the analysis through my interaction with my participants as well as the generated data.

2.4 Rationale for using thematic analysis

After a research question has been formulated a method of analysis that best addresses the question must be selected (Harper, 2012). Based on the overarching aim of this study - exploring mental health service-users' experiences of treatment pressure - thematic analysis, interpretative phenomenological analysis and grounded theory methods were considered. Interpretative phenomenological analysis is suited to exploring the subjective experience of individuals, whilst grounded theory is useful when interested in exploring social processes surrounding a phenomenon (Harper, 2012). Given that thematic analysis has been described as best fitting with research questions that aim to explore "the specific nature of a given group's conceptualisation of the phenomenon under study" (Joffe, 2012, p. 212) this method was deemed to be the most appropriate to use in this study.

Thematic analysis is "a method for identifying, analysing and reporting patterns (themes) within data. It minimally organizes and describes your data set in (rich) detail" (Braun and Clarke, 2006, p.79) and is compatible with a contextual constructionist epistemological position. The process of thematic analysis entails searching across a data set to distinguish repeated patterns of meaning, or themes (Joffe, 2012). Patterns of meaning can be located at either the manifest level (directly observable in the information) or the interpretive level (underlying the phenomenon). The former are associated with realist epistemology whilst the latter with constructionist epistemology. Given the contextual constructionist stance of this study, both observable patterns of meaning and those influenced by contextual factors were considered. This permitted the generation of themes which concerned both explicit and implicit content (Joffe, 2012).

Themes can be generated within a thematic analysis from either a data-driven (inductive) approach, or a theory-led (deductive) approach. Braun and Clarke (2006) stated that an inductive thematic analysis aims to organise and describe data "without trying to fit it into a pre-existing coding frame" (p.83) whilst deductive thematic analysis comprises mapping data on to pre-conceived areas of theoretical interest. Given the exploratory aims of this research, an inductive, data-driven thematic analysis was considered most congruent. However, Joffe (2012) argued that a dual deductive-inductive approach enables the researcher to approach the data set open to new ideas and concepts but with an awareness of the existing literature; thus avoiding repetition of previous research and facilitating the generation of new understandings in relation to the topic. Therefore a combined inductive-deductive approach was used in this study, with more emphasis placed upon a data-driven approach.

2.5 Researcher reflexivity

Reflexivity "refers to the ability to engage critically in understanding the contribution the researcher's experiences and circumstances have had in shaping a given study (and its findings)" (Harper and Thompson, 2012, p.6). It is important for the researcher to step back from and reflect on the processes of data collection, data analysis and reporting of the findings so as to ensure that their own hidden assumptions do not unknowingly or uncritically affect these.

A contextual constructionist thematic analysis method assumes that researchers generate data *with* participants; and that themes are constructed through the researcher's interactions with others, as well as their idiosyncratic perspectives and research practices. Through 'personal reflexivity' the researcher attempts to think about how their own personal history and values impact the study (Harper and Thompson, 2012). Runswick-Cole (2011) used the term 'positionality' and stated that by researchers clarifying this, they "reflect on aspects of their lives that might influence the conduct of their research study" (Runswick-Cole, 2011, p.91). This includes a consideration of the impact of their role and presence, and

clarifying the values that have influenced the research (Spencer and Ritchie, 2012).

The notion of researcher reflexivity has been critiqued by Rose (1997) who argued that it can be hard for researchers to recognise and identify their positionality. I agree that it is difficult for me to ascertain all of the values and assumptions I hold, and to fully comprehend my role and influence on this study. However I have endeavoured to maintain reflexivity throughout the formulation of this study, the implementation of it, and during the write-up, by keeping a reflective diary (see appendix B for excerpts) throughout the process and engaging in discussions both in supervision and with peers/colleagues.

In keeping with my contextual constructionist epistemological stance I recognise that both the data generation and my analysis of it have been constructed within my personal, social and cultural contexts. It therefore seems relevant at this point to give the reader a sense of what I have brought to this research. I am a 28-year-old, white British female training to be a clinical psychologist. Both prior to and during training I have worked in the field of mental health, and through these experiences have formed ideas about what is helpful or less helpful practice when people are in distress. I view the use of force or coercion as most commonly unhelpful unless in extreme circumstances, and I choose to value people's understandings of their distress over reductionist medical conceptualisations. I have been an employee of the National Health Service (NHS) since 2006 and recognise that I therefore participate in a system that uses pressure and coercion in order to ensure people adhere to treatments they would not otherwise choose. Following my undergraduate degree I worked as a nursing assistant in a forensic mental health unit and in this role was both a witness to and involved in some of the forceful processes used in these environments including: restraint, seclusion and depot medication. A number of emotions are attached to these experiences including, guilt, regret and anger. All of these contexts and more will have influenced how I participated in the conversations with those who I have interviewed, how I subsequently made sense of the conversations and transcripts and how the participants interacted with me. Reflection on them is therefore important in consideration of what contexts the

interviews and the thematic analysis were constructed. Further consideration of my role and influence in the research is presented in the discussion chapter.

2.6 Ethical issues and approval

Ethical approval was granted by the University of East London Ethics Committee (see appendix C). Emotional distress as a result of discussing their experiences was the key ethical concern regarding participants. The interview schedule (see appendix F) was designed so that participants only shared what they wanted to therefore the risk of emotional distress was deemed low. All participants were informed that they could stop the interview or take a break at any time if they would like to. It was hoped that my experience as a trainee clinical psychologist would enable me to manage the distress a participant felt during the interview. I was also able to offer participants contact details for places where they could access further support should they wish to. During the interviews, none of the participants became upset or needed any after-care.

2.7 Recruitment procedure

An email (see appendix D) was sent to multiple mental health service-user groups in London (none of which were NHS-run), inviting them to participate in the research which was then forwarded on by them to their members. Interested persons were asked to contact me via a study specific email address. Eleven people contacted me to enquire further about the research. They were all emailed an information sheet (see appendix E) following which ten people wished to arrange a mutually convenient time and location in which to conduct the interview.

2.7.1 Inclusion criteria

All participants had to have been mental health service-users at some point in their lives and aged between 18 and 65 years.

2.7.2 Exclusion criteria

Due to constraints of time and resources those who were not fluent in English were unable to participate in the study as it was not possible to have an interpreter present during the interviews.

2.7.3 Participant characteristics

Table one below summarises self-defined demographic and diagnostic information of all the participants, as well as their experiences of sectioning under MHA (1983).

Eight participants defined their ethnicity as ‘white British’, one as ‘British Chinese’, and one as ‘human’. These are not included in the table below to preserve confidentiality.

Table 1: Overview of participant demographics

Pseudonym	**Gender**	**Age range (years)**[8]	**Diagnosis(es) received from services**	**Experience(s) of sectioning under MHA?**
Amelia	Female	40-44	'Bipolar disorder'	Yes
Caroline	Female	50-54	'Psychosis'	Yes
Christine	Female	55-59	'Adjustment disorder with psychotic features'	Yes
Jane	Female	45-49	'Bipolar disorder'	Yes
Kevin	Male	35-39	'Depression'	Yes
Lucy	Female	60-64	'Severe depressive disorder'	No
Mark	Male	50-54	'Manic', 'paranoid delusional'	Yes
Michael	Male	60-64	'Anxiety', 'panic disorder', 'Asperger's syndrome'	No
Susan	Female	50-54	'Schizoaffective disorder'	Yes
Toby	Male	55-59	'Bipolar disorder', 'autism spectrum disorder'	Yes

[8] I have used age ranges to maintain the anonymity of participants.

2.8 Data generation procedure

2.8.1 Semi-structured interviews

Interviews are the most commonly used method of data collection in qualitative research as the data they generate can be analysed in a variety of ways and there are generally fewer logistical hurdles to overcome in arranging them (Willig, 2008). Atkinson and Silverman (1997) warn against the uncritical, overuse of interviews in order to collect data and suggest that there is a danger of viewing what participants say as spontaneous, rather than constructed within the context of a conversation and in response to the researcher's questions. Focus groups were also considered as a form of data generation for this study but due to the limits of time and resources, semi-structured interviews were considered most appropriate.

2.8.2 Interview schedule

All of the conducted interviews were loosely led by an interview schedule (see appendix F). As Charmaz (2006) recommended, the interview schedule devised consisted of a few broad, open-ended questions, followed up by questions that invited a more detailed discussion about the topics of interest. Constructionist interviews are concerned with learning about the interviewee's definitions of the terms they use, situations, events as well as eliciting assumptions and implicit meanings and rules (Charmaz, 2006). The aim of the interview schedule in this study was to facilitate the exploration of how participants understood and defined a range of treatment pressures; what they considered to be the effects of these experiences; what they feel could be done differently; the role of the contexts of both gender and ethnicity in their experiences of treatment pressures; and what had been helpful in managing these experiences. The focus of the last section of the interview was purposefully more positive so that the interview didn't end with the exploration of particularly difficult emotions or memories. As data generation and preliminary analysis progressed, slight amendments were made to the interview schedule in order to explore pertinent issues. For example, during the

first couple of interviews information regarding offered treatments was spoken about in relation to treatment pressures. Accordingly questions that explored the role of information in these experiences in more depth were introduced during subsequent interviews.

2.8.3 Interview process

Prior to the commencement of each interview all participants signed a consent form (see appendix G) and were reminded about confidentiality and its limits. I also checked they felt comfortable to proceed with the interview in the setting in which we met. The interviews lasted between 42 and 102 minutes and each participant was compensated £15 for their time after its completion.

The payment of £15 was considered justified to provide acknowledgement of the time given to the study. The amount was not considered enough to serve as an incentive to participate or bias the results. Russell, Moralejo and Burgess (2000) reported that potential research subjects thought recognition of participants' time and effort should be emphasised more by researchers. The money was provided by the research fund of an advisor of the research[9]. Payment of participants was raised in the ethics application and was not considered problematic.

Although the structure of the interviews was loosely shaped by the interview schedule, I aimed to maintain a conversational approach during the interviews in order to increase the quality of the data. For example, I asked the questions in varying order, dropped questions and added new ones to respond more dynamically to what participants said, as one can with semi-structured interviews (Runswick-Cole, 2011).

Willig (2008) highlights the need for rapport to be established between the interviewer and the interviewee to enable this type of interview. She recommended that the researcher use the participant's language and restates words or comments in their questions in order to demonstrate their attention and to maintain coherence. For example, I said, "Can I ask, sorry Christine, can I take

[9] Professor George Szmukler at the Institute of Psychiatry took on the role of advisor for this study.

you back a little bit more, because you've said something that…stayed in my mind, when you first went into hospital you went like a lamb. And I'm interested in that" (interview with Christine: lines 429-430).

I transcribed all of the interviews, using an adapted version of the transcription conventions described by Banister et al. (1994) (see appendix H for summary of conventions) and changed all identifying information.

2.9 Data analysis procedure

Elements of social constructionist grounded theory (Charmaz, 2006) were used to generate the thematic analysis; such as line-by-line coding, focused coding, constant comparison and writing memos. These are explained below.

2.9.1 Systematic coding

Following repeated reading of the transcripts for familiarity with the data, I embarked on the process of systematic coding, which refers to the naming of segments of data with a label that categorises, summarises and accounts for each piece of data. Through coding the researcher attempts to define what is happening in the generated data and starts to make sense of what it means.

2.9.1.1 Generating initial codes: Line-by-line coding

Lline-by-line coding formed the initial part of the analysis and served to ensure that the analysis was grounded, by maintaining my attention on small fragments of all parts of the data. This part of the analysis remained close to the data and tried to portray both meanings and actions. Charmaz (2006) advocated speed and spontaneity in this part of the analysis and the use of gerunds (i.e. non-finite verbs or words ending in 'ing') when proceeding with initial coding in order to invoke the language of action and processes rather than topics, an approach I sought to emulate (see appendix I for example of line-by-line coding).

2.9.1.2 Focused coding and constant comparison

Following initial coding, focused coding was carried out, during which the most useful, salient initial codes were selected and tested against extensive data through constant comparison (see appendix J for example of focused coding). Constant comparison is "a method of analysis that generates successively more abstract concepts and theories through inductive processes" (Charmaz, 2006, p.187) which consists of continually comparing data with the constructed codes and developing themes.

2.9.3 Memo-writing to define and name themes

Throughout the process of coding I wrote memos as a record of the development of the analysis. This enabled me to analyse my ideas about the codes and develop themes (see appendix K for example of memo-writing). Writing memos involved defining themes, justifying the labels given to them and tracking the relationships between them (Willig, 2008).

Through the process of abduction[10] and the continual review and comparison of the transcripts, codes, themes and my ideas about them, I constructed the thematic analysis which I felt was the most credible interpretation of the generated data.

2.10 Addressing the quality of the research

How qualitative research should be assessed in terms of quality has been much debated. Spencer and Ritchie (2012) argue that unlike quantitative research (which adopts notions such as reliability and validity) the criteria to assess the quality of qualitative research "should be framed as guidelines rather than prescriptive rules" (p.227). This is because qualitative research can adopt many different ontological and epistemological positions, and uses flexible and non-

[10] Abduction involves the initial examination of data, scrutiny of all the possible explanations for it, and the construction of hypotheses which are confirmed or disconfirmed until the most plausible explanation of the data is arrived at.

standardised methods. Various authors have suggested frameworks to use in the assessment of the quality of qualitative research (Henwood and Pidgeon, 1992; Elliott et al., 1999).

Studies that adopt a contextual constructionist epistemology are expected to demonstrate the relationship between accounts of the phenomenon and the situational, personal, cultural and social contexts within which they were generated (Willig, 2008). Therefore contextual constructionist studies such as this one, can be evaluated by an assessment of how grounded the thematic analysis is within the contexts in which it was generated.

Recently Spencer and Ritchie (2012) identified widely recognised quality principles that qualitative research should be concerned with: contribution, credibility and rigour. The notion of contribution is concerned with the value and relevance of the research evidence; credibility refers to whether the claims made by the research are plausible and defensible; whilst rigour enquires about the conduct of the research, the decisions made and the dependability of the evidence. I have attempted to consider aspects pertaining to the rigour of the research within this chapter, including a discussion of: the documentation and the reflexivity of the research process; why I have used the research design and methods I have done; ethical issues; selection of participants; as well as the processes of data generation and analysis. Throughout this report I have endeavoured to be clear and coherent, another feature of a rigorous study. Issues regarding this study's contribution, credibility and rigour will be examined further in the discussion chapter.

Chapter 3: Analysis

3.1 Overview of chapter

In this chapter I will outline the thematic analysis constructed from the interview data by describing and elaborating on the overarching theme, themes and sub-themes developed.

3.2 Experiencing and managing treatment pressure

Figure 1 below provides an illustration of the overarching theme that was constructed from the data, 'experiencing and managing treatment pressure'.

3.2.1 Overview of the analysis[11]

Many participants described how they had experienced a range of different treatment pressures including (but not exclusively): being verbally pressured to comply with their medication; having no choice with regards to complying with treatments or what treatments were available; having movement restricted whilst staying on an inpatient ward; being threatened; being restrained; being pressured to go to hospital (through both persuasion and force); and being forcibly given medication. Jane and Lucy also talked about being pressured into participating in psychological-related therapies whilst staying in therapeutic communities. Participants' accounts suggested that the experience of treatment pressure was constructed by: the nature of the treatment pressure; the person's social category status (e.g. gender, social class); and their relationships with services in general, the person exerting the pressure and others. In parallel, the experience of treatment pressure was described as having a personal impact, an impact on their relationships with services and others, as well as their social category status

[11] As explained in the methodology chapter, I have taken a contextual constructionist epistemological stance and therefore recognise that this analysis does not map out reality but is itself a construction of reality.

(i.e. gender, ethnicity, social class). Participants appeared to construct an understanding of treatment pressure in relation to their view of themselves and services, based on the experience and its effects. They also seemed to try and manage their experiences of treatment pressure by taking control of them in different ways and at different times. Broad strategies aimed at taking control of the experience of treatment pressure were described and included: fighting the system (e.g. by showing resistance); escaping or minimising contact with services; complying with treatment pressure; and seeking other avenues of help or support. The strategies used to take control appeared to be mediated by participants' constructions of treatment pressure in relation to both themselves and services (i.e. constructing oneself as ill and in need of others taking control was likely to foster compliance; whereas understanding one's distress in context and services as punishing, was likely to cultivate trying to minimise one's interactions with them). The management strategies used by participants appeared to mediate their relationships with services in general and the person exerting the pressure; and the impact that the experience of treatment pressure had on them as an individual.

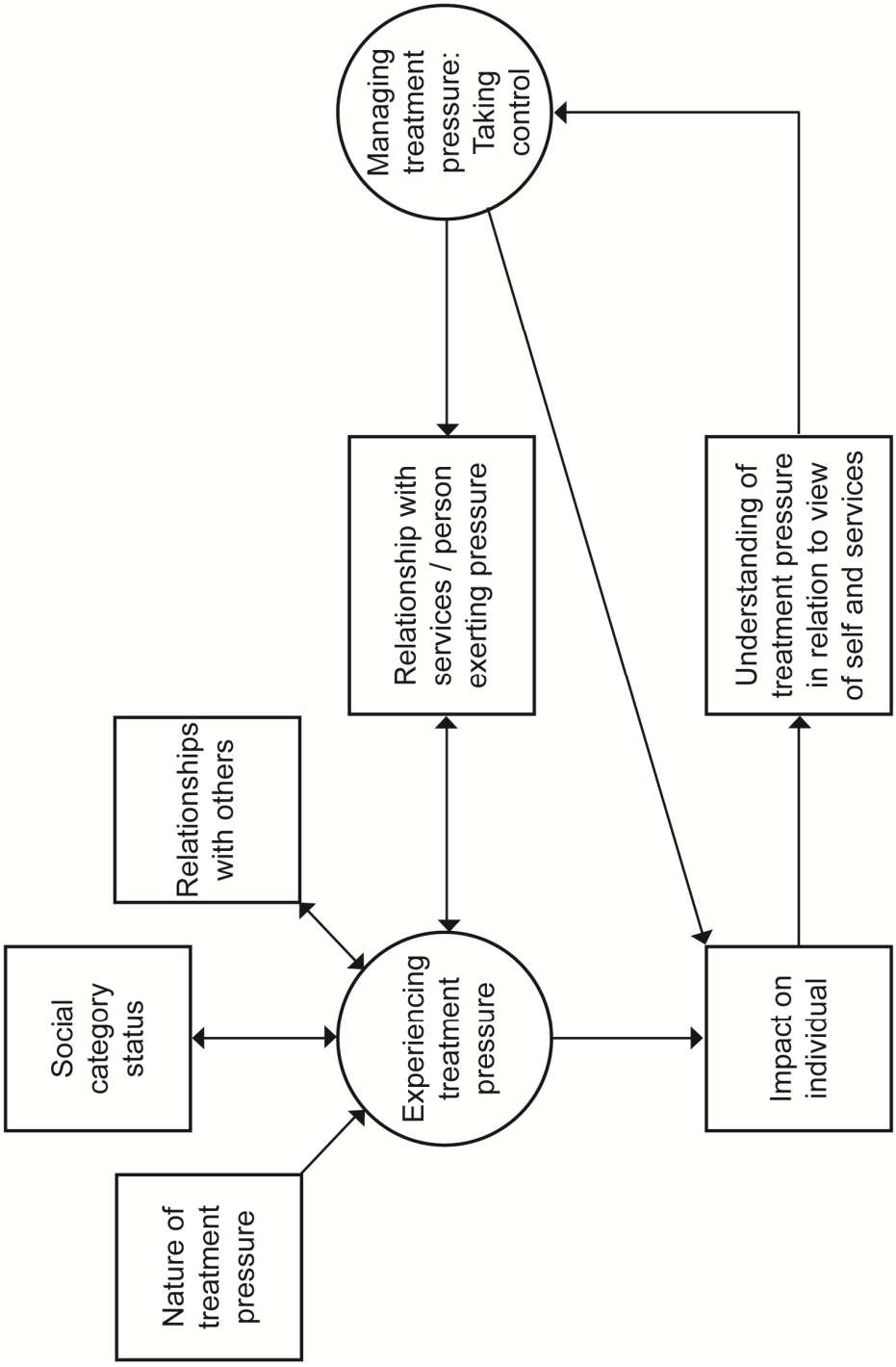


Figure 1: Illustration of the overarching theme: Experiencing and managing treatment pressure

Table 2: The themes and associated sub-themes[12] that comprise the overarching theme, 'experiencing and managing treatment pressure'.

Overarching theme	Themes	Sub-themes
3.2 Experiencing and managing treatment pressure	3.2.2 A personal experience	3.2.2.1 Feeling "sub-human", and powerless
		3.2.2.2 Shattering of worldview
		3.2.2.3 Self-identity
		3.2.2.4 "They don't know me"
	3.2.3 A relational experience	3.2.3.1 A battle: "Them against us"
		3.2.3.2 The importance of relationships
	3.2.4 A culturally bound experience	
	3.2.5 Taking control: "it's fight, flight or comply"	3.2.5.1 Showing resistance
		3.2.5.2 "Taking responsibility": going it alone
		3.2.5.3 "Harnessing coercion"
		3.2.5.4 Seeking information and support

[12] All themes and sub-themes were generated from data across two or more interviews.

I will now go on to describe and explicate these themes (underlined) and sub-themes (italicised) in more detail. Both will be illustrated using data extracts[13], reflecting how all components of the analysis have been constructed from the data.

3.2.2 A personal experience

Most participants spoke about the experience of treatment pressures had affected them in a personal way. Some maintained more of a sense of distance in their accounts of their experiences and the personal impacts of them; by using less eye contact, muted voices, delaying talking about them, or not talking about them at all. Others talked about their experiences and their effects in a much more detailed, intimate way. These reactions perhaps illustrate different ways of coping with the experiences, such as not thinking about them, separating them off from oneself or engaging with them in a different way to other aspects of the experience.

3.2.2.1 Feeling "sub-human" and powerless

A number of the participants portrayed experiencing themselves as being "subhuman" (Susan: 317) in the context of the experience of treatment pressure. Susan also talked about how she felt dehumanised by the way staff treated and talked about her.

> They say things like, they're rounding you up to go downstairs for your fifteen minute break, and they, they take you down in groups of say two or, three or four <Hannah: mm> and they say, "oh I've

[13] Data extracts are indented. Where text appears in quotation marks in the main body of the text, these are direct quotes from an interview. The participant and line numbers of the interview will be given in brackets unless the participant's name has already been stated in the sentence. See appendix H for transcription conventions used.

> got four of them now". And they just you know <Hannah: yeah> four what, four animals? I'm taking four of them down.
>
> Hannah: What's the effect of hearing things like that?
> Susan: Very depressing <Hannah: mm> very dehumanising (Susan: 301-306).

Many others also seemed to emphasise interactions in which they felt unheard, othered and pathologised by staff. Toby described how he felt that his refusal to take medication was not listened to as his personal view on medication, but was rather incorporated into his pathology which could be used as a reason to exert further treatment pressures in a somewhat no-win situation.

> You see even refusal, even refusal is pathologised…If you disagree with a doctor you're pathologised as having lack of insight. You know, or non-compliance…Your lack of insight proves you're unwell, your non-compliance proves you're unwell (Toby: 482-488).

In describing these processes participants both implicitly and explicitly alluded to feeling demeaned by staff and their powerless position in relation to both them and services. This sense of powerlessness then seemed to impact on how able they felt to manage different treatment pressures and their subsequent reactions.

> I feel that you know, it's very difficult if, to be in my position, and erm, erm you know, try to resist what they're doing. Which is what I would like to do, but you know the whole, you've got the whole powers of the state against you. So it makes me feel depressed actually (Susan: 200-203).

Participants' accounts of their powerlessness often involved a portrayal of their feelings of extreme fear and vulnerability experienced when subjected to treatment pressures. Amelia described her experiences of vulnerability in the face of forced ECT. She conjured a vivid image of being outnumbered and overpowered by staff as well as giving a moving account of feeling highly distressed and terrified by the experience.

> They surrounded me and started to push me down on the table you know, and they needed to get a general anaesthetic into me and stuff…I was kind of struggling on this table and erm, and it was awful, I mean I was, I was terrified and I was crying and you know I was begging them not to do it…but they were pushing me down and er, and then I could kind of see this needle approaching and kind of going in and I knew that, it was a horrible feeling because you kind of, I kind of knew that once the injection was in, that was it, there was nothing that I could do (Amelia: 370-378).

Amelia continued to describe her sense of being completely overwhelmed and powerless during this experience later in the interview, when she went on to describe how in this incident she was lying down on her front, in her pyjamas and how the whole process felt "like being violated" (line 601). Amelia also described how being stripped of her autonomy during these experiences led to long-lasting effects when she talked about experiencing flashbacks and being unable to get many of the incidents out of her head, particularly ones of forced treatment. Susan similarly described how the process of being restrained by a man brought back her previous traumatic experiences of domestic violence. These findings are suggestive of a traumatic response to particular treatment pressures, which I will return to in the discussion.

> To be held down by a man is particularly horrible <Hannah: mm> And I mean you know, supposing that, I mean I haven't personally had experience of erm, well I have had experience of domestic violence actually and erm, you know to be on the receiving end of that from a man is just the same, it brings it all back <Hannah: mm> it's horrible (Susan: 336-340).

These accounts remind us that it is paramount to remain mindful of the personal history of service-users and how this might relate to being subjected to treatment pressure, particularly given the evidence suggesting links between mental health problems and childhood abuse (e.g. Read et al., 2005).

3.2.2.2 Shattering of worldview

Both Amelia and Christine described how the process of being made to accept treatment that they were opposed to having, caused them to re-evaluate what they thought about the world and living within it. They seemed to be describing how their experiences of treatment pressure had in some ways shattered their previous beliefs about the justness and safety of the world in which they lived. This is similar to the assumptions that cognitive models of posttraumatic stress propose are challenged by traumatic events (which will be discussed in more detail in the next chapter).

> I mean essentially it's just, it's a very strange feeling because you know you grow up thinking that you know effectively you live in a free society <Hannah: mm> and if you are a law abiding member of that society, in general you will have the freedom to make the decisions <Hannah: mm> about what you do, where you go, erm, that no one really can, unless you do something criminal <Hannah: mm> nothing can restrict those. And all of a sudden you find yourself in a position where that's just not the case (Amelia: 566-572).

Christine talked about the enduring nature of these cognitive effects, seemingly describing how life could never be the same for her again following her experience of forced hospitalisation and treatment. Her description of an inability to ever feel safe again seems to reflect the sometimes traumatic nature of treatment pressures.

> You know, well, if you think you're going to die, you know that is pretty hard, that you're going to die or you're going to be brain damaged. You can never feel safe again. I don't feel safe (Christine: 704-706).

In order to incorporate their experiences of treatment pressure and the effects that these had had on their lives, both women seemed to shift or re-build their worldview. In doing this they formed new ideas about their

position and security in the world, and their ability to trust others. They appear to have dealt with this change in outlook in different ways which is illustrated in the 'taking control' theme described in section 3.2.5.

3.2.2.3 Self-identity

Similarly to their worldview, some participants described how their self-identity was impacted upon by their experiences and had to be re-negotiated in the light of their experiences, both within inter- and intra- personal contexts.

> I mean my identity was at a complete low point because first of all I was absolutely devastated by what had happened, by the experience (Amelia: 731-733).

Jane seemed to describe how the negative impact of complying with treatment pressures and taking medication rendered life as she was living it and who she had become meaningless and empty for her.

> I'd been on increasing amounts of this mood stabiliser carbemazepine er, for three or four years by then and erm, life just wasn't worth living, it was just simply not worth living. I, I watched telly for twelve hours a day and I slept for twelve hours a day (Jane: 349-351).

Susan, who at the time of the interview was under a CTO, described feeling like a "slave" because she felt she had no choice but to obey treatment pressures despite not wanting the medication.

> If I cooperate it just makes me more of a slave than I was otherwise. That's what it feels like, being you know, part of a slave underclass (Susan: 181-182).

Susan appeared to be describing how her self-concept, in the context of a CTO and a continued threat of hospitalisation, became dominated by being a recipient of medication. Both she and Toby also likened their inpatient stays to "being in prison" (Susan: 129) perhaps implying that they lose all their rights as a free

person and highlighting the injustice they feel in relation to the coercive nature of current mental health law. Amelia similarly compared her experiences to the criminal justice system potentially in an attempt to make sense of them. She talked about being made to feel like a criminal and how this experience permeates into life beyond the ward.

> You feel like you know, a sort of criminal who's sort of violated their rules of parole sort of thing <Hannah: mm> and it was very weird 'cause you sort of there afterwards just thinking you know, life has got really bizarre, 'cause you plan a holiday <Hannah: mm> you go and buy your walking boots and your gear and whatever, and you book the apartment and you just don't think about clearing it with the mental health act (laughs) it's a very strange thing (Amelia: 890-895).

This extract seems to describe how her experiences of treatment pressures had an impact on how she and others viewed her - that didn't fit with her sense of self prior to accessing psychiatric services - as well as how she was able to behave in the world beyond the psychiatric unit.

During the interviews many participants distinguished between themselves now and during times of crisis, when they thought of themselves as "ill" (Caroline: 24) - seemingly in an attempt to separate their patient-identity from their self-identity.

> I didn't know I was mad at that stage you see. I woke up in a mental hospital and I think my first question was, is this heaven, have I died and gone to heaven? (Mark: 74-76).

From the accounts given in this study it seemed that participants' experiences could have quite dramatic and even traumatic effects. Perhaps this separation of identities helped to enable participants to carry on with their lives after the acute distress had passed.

3.2.2.4 "They don't know me"

It appeared as though participants felt that who they were and what they felt about what was happening to them could get "lost" (Jane: 328) in their experiences of treatment and treatment pressures. Participants seemed to perceive staff viewing them as one of many patients, rather than an individual affected by what was happening to them.

> I think that people who work within the environment get immune to actually what it means…it is just one of the day-to-day things that happen, I think you lose sight sometimes, of actually what it's like for the individual…you're effectively detached from a process which for each individual is deeply disturbing and violating (Amelia: 631-640).

This impression that staff were cut-off from the lived experience of treatment pressure for individual service-users seemed to lead to feelings of isolation and being alone. What participants described as a very distressing time for them, seemed also to be a 'run of the mill' occurrence for staff, a natural part of their day job. This sense of loneliness was portrayed elsewhere in the interviews. Many participants gave accounts of their first experiences of treatment pressure, in which they were put into to an alien system that they knew little about and were fearful of.

> I was absolutely shitting myself. You know, I mean that's the trouble, they could see I was a vulnerable, scared person, I was scared, and they just enjoyed <Hannah: mm> making me more scared. You know, I mean obviously now if it ever happened again, which I'd hope not, erm, I know the ropes a bit more (Christine: 392-396).

Here Christine seems to be interpreting staff members as making the most of her naivety and deliberately inducing fear. This sense of feeling punished appeared to be echoed in a number of other interviews and will be discussed in section 3.2.3.1.

The “they don’t know me” (Susan: 438) sub-theme also seemed to incorporate the feeling of unjustness at being made to comply with treatments. In the extract below, Susan appears to reason that as staff do not know her they cannot know what’s best for her, and therefore shouldn’t be able to force her to take medication. I had just asked Susan why she had said coercion had no place in mental health:

> It’s wrong to force things on people. You know and they can justify it, they can say oh yes but you’re better if you take it, but erm they don’t know that, because they don’t, they didn’t know me before <Hannah: mm> they didn’t know me before this all happened. And they didn’t, they don’t know me…they only know me when, when I’m erm, experiencing what I’m experiencing which, as I said, as far as I’m concerned it’s, it’s the erm, side effects of of the drugs, the withdrawal effect of the drug (Susan: 435-441).

As well as describing how her individuality was lost in the context of services, she also seemed to be implying that the treatments offered to her caused her distress. Other participants similarly seemed to explain the distress they had experienced since being involved with mental health services as a direct result of their interactions with them; including both the treatments they received and the treatment pressures they were subjected to. When describing his experiences in a ward-round Toby said the following:

> You know more pathologisation, “you’re agitated”, well you know excuse me, I’m in hospital being treated like shit…isn’t agitation an appropriate response? (Toby: 886-889).

He seemed to be describing how his reactions to being on the ward were described as a symptom by the team, rather than a normal reaction to a horrible situation, which he felt they were.

As well as explaining their distress in terms of their interactions with mental health services, some participants seemed to explain the distress they

experienced (which had led to them initially having contact with mental health services) in terms of difficult life events. These participants, unlike others, did not make reference to the medical model's conceptualisation of distress as 'mental illness'. Many also spoke about how those around them (i.e. mental health services, family and friends) did not seem interested in their understanding of their distress, seemingly preferring biomedical conceptualisations. Jane spoke about feeling that both her family and services medicalised her distress in order to avoid seeing it in context and recognising the underlying causes, after I commented on the wide range of treatment pressures she had experienced from both of them.

> Forget the [personal] history that is completely unspoken and actually the, the undercurrent to the illness itself. Because psychiatry's not interested in that at all either, so they're all dealing with surface issues whereas the patient is actually struggling with something much much deeper, which is never going to be addressed within that structure because the psychiatrist and the patient's parents, family, are all wanting to keep it superficial, chemical and outside the realms of the messy undercurrent which nobody wants to look at (Jane: 84-90).

The sub-theme, "they don't know me" indicates how some participants felt that who they were as a person, and their ideas about what was happening to them, were not deemed important by others and therefore got lost. These processes seemed to increase the sense of treatment pressure.

3.2.3 A relational experience

All participants spoke about experiencing treatment pressure in the context of their relationships with services in general and/or the person exerting the pressure. These relationships seemed to contribute to the construction of the experience of treatment pressure, and in parallel, be affected by them. Staff in health services were most frequently described as exerting treatment pressures,

including general practitioners (GPs), psychiatrists and nursing staff. Family members and friends were described as exerting pressure independently of staff. Participants also talked about staff using family members to exert pressure.

> I think that [family exerting pressure] was you know, something that the doctors encouraged as well, you know it's in their interests to get the family putting pressure on the individual to continue to take the medication (Jane: 74-77).

The extract from the interview with Jane above appears to describe how she felt that her family and the professionals involved in her care joined forces to ensure her compliance with treatments. These types of interaction perhaps played a role in the powerlessness and aloneness that ran through many of the accounts of treatment pressure, and often seemed to lead to a fracture in the relationship with services and staff entailing a loss of trust in them. Participants often described avoiding services for fear that they would go through similar experiences again.

> To have these constant erm, er being turned down for treatment <Hannah: mm> and so on, erm and being just left in a complete vacuum erm, I think erm, I lost trust in people, I lost trust in professionals (Michael: 454-456).

This avoidance of services will be discussed further in the theme 'taking control' (section 3.2.5).

3.2.3.1 A battle: "Them against us"

The inequality in the relationships between service-users and staff appeared to create an "us and them culture" (Toby: 604-605). This "them against us mentality" (Amelia: 620) meant that participants' descriptions of the relational context of their experiences, and their interactions with staff regarding treatments and treatment pressures, often seemed like a battle in which they were on opposing teams. This division in part, seemed to be created by participants feeling like they were often not informed about what was happening to them by staff. This

appeared to reduce participants' power when experiencing treatment pressure. Participants seemed to enter into the unknown feeling unprepared, naïve and vulnerable, which impacted on how able they felt to manage or resist the pressure.

> When I was sectioned they didn't actually tell me I was sectioned. I've since found out this is usual, that they don't tell you. It's like a big secret (laughs). <Hannah: mm> And I think, erm, I think they were supposed to tell me on the ward, they don't like to tell you before the ward I think because then you would fight and wouldn't go into the ward. So I went into the ward like a lamb not knowing what was happening (Christine: 18-23).

Some participants also portrayed this sense of fighting a losing battle when they described 'having no choice' with regards to complying with treatments, as a form of treatment pressure. This lack of choice was mentioned both in the context of treatment under the MHA (1983) and outside of its use. A number of participants discussed how the mere existence of the MHA (1983) served as a pressure to comply with treatments even without staff members invoking it, implying that psychiatric staff always have the weight of the law behind them further unbalancing the distribution of power.

> But in my experience a lot of coercion actually goes on without the mental health act necessarily being erm, brought in, just through the fact that the mental health act could be brought in (laughs) erm, and I mean most of my experience has actually been in that category, although I have been sectioned and treated forcibly, erm but only, only once. But (laughs) I've been almost sectioned or been told that if I didn't comply with certain things erm, that I would be sectioned on numerous occasions (Amelia: 39-44).

Feeling threatened by staff was commonly talked about in participants' accounts of their experiences of treatment pressures and the relational context in which

they occurred. Incidents where they had been verbally threatened by staff with the effects of not complying were frequently described.

> I've been told that erm, "you must take this medication for the rest of your life, it's the only option and if you don't you're going to be in and out of hospital for the rest of your life and probably die early" (Jane: 97-99).

Some talked about how witnessing others' treatment was similarly experienced as a threat to comply, indicating how the wider relational context (beyond participants' relationships with staff) served to create the experience of treatment pressure.

> And actually it's the first time I've ever seen anyone have a depot injection, because they used to leave the medical room open, so I saw someone having a very big injection. So I immediately made an appointment with the nurse and said, no the doctor actually, and said, "why is she having that?" And they told me a little bit about depot <Hannah: mm> and I said, "oh I never want to have that, I never want to do that". And you know and she was saying to me about taking the medication and erm, so yeah I learnt about depot when I was sectioned and I just thought there's no way I'm going to do that (Caroline: 204-211).

In order to incorporate the experiences and their effects into a coherent life story, participants appeared to make sense of treatment pressures in relation to their view of themselves and services. As described above, participants' relationships with staff were often portrayed as a battle. In these accounts the behaviour of staff appeared to be described as wrong and excessive and explained in terms of defensive practice and punishment by a number of participants. Many participants gave examples of when they felt that staff members had abused their positions of power and described these behaviours as "wrong" (Susan: 262). Amelia spoke of feeling as if one of her previous psychiatrists had lied about the effects of not complying in order to exert pressure on her to accept treatment.

> He started going into all this stuff you know if you're sectioned you're, it'll go on your passport (laughs). I remember him saying it was going to go on my passport and he said you know and you'll never be able to go and visit your brother in America again…I didn't know that wasn't true. I mean I was by myself in a hospital <Hannah: mm> in a room <Hannah: mm> by myself with this very threatening psychiatrist (Amelia: 186-192).

This extract seems to imply that Amelia felt that this professional had used his power to take advantage of her vulnerable position; young and alone in a psychiatric hospital. Others described the actions of staff and services as excessive.

> Restraint is really supposed to be last resort. I mean it's er, you know in my case it's always been used as a first resort (Toby: 175-176).

These extracts appear to suggest that participants felt there can be 'foul-play' on the part of staff in order to ensure compliance with different treatment pressures. Participants often described the use of excessive and wrong behaviour by staff as incomprehensible. Others appeared to portray staff as following the protocol of the wider system.

> I don't understand why they do the things they do. I suppose they erm, they're just following orders (Susan: 49-50).

Here Susan seemed to be framing the action of staff as doing things in order to get the job done. She also appeared to invoke the Nuremberg defence (Best, 1994) thus implying that staff don't act on their conscience or take personal or moral responsibility for their actions. Other participants appeared to describe staff behaviour as defensive practice. They portrayed being subjected to "if it ain't broke don't fix it" (Toby: 958-959) reasoning in which psychiatrists and GPs had been loathed to reduce or change their psychiatric medication.

> They [staff] say well as long as someone's stable just keep taking it [medication] I suppose (Mark: 96).

Some seemed to explain staff actions within the risk-averse culture in which services have to operate; in which societal fear of 'madness' often driven by media portrayals, mean that service-users are hospitalised and put on medication in order to minimise the risk of anything untoward happening. This type of risk-aversive reasoning and behaviour seems unfounded given that the prediction of violence amongst psychiatric service-users is far from accurate (Szmukler, 2003). Despite the inaccurate prediction of risk, participants seemed to describe how conservative and particular cost/benefit analyses are made within this context; which can feel unfair, unjust and wrong to those whose lives they directly impact upon.

> The patients are a nuisance, you know, they don't take their drugs, they keep ending up in hospital, they go and commit suicide, doesn't look good on their (laughs)…as long as they keep them drugged up, they're not getting into any trouble (laughs) <Hannah: mm> then they're you know, then they're safe…it's not going to get in the paper that they over-drug someone, but it will get in the paper if that person goes off and kills somebody (Christine: 896-903).

Some participants seemed to feel that treatment pressures were used by staff as punishment at times, like they were a powerful upper hand that could be wielded over them. They described noticing an increase in treatment pressures when they did things that they perceived as angering staff, such as resisting treatments. Toby described how making a protest led to forcible treatment:

> I thought how am I going to protest, what can I do to protest?…I stripped off naked and I started parading, parading around the ward naked. And of course they didn't like it. <Hannah: And what happened?> Well (laughs) well, they restrained me, they restrained me, took me to my bedroom and they injected me (Toby: 546-551).

3.2.3.2 The importance of relationships

As well as the negative impact of treatment pressures on relationships, participants spoke about how a good relationship with the person exerting the pressure could moderate and ease the experience. Some talked about the importance of having consistent relationships over time; in which they felt identified as, cared for and treated as a human being. This type of relationship perhaps helps to counter the processes illustrated in the 'feeling sub-human and powerless' sub-theme described above.

> [A few moments before I had asked Jane about what was helpful in managing the experiences of treatment pressure]
> It does make those professional relationships <Hannah: mm> even more important, that there is stability and continuity in them, erm and some way to feel connected as a person, rather than simply you know, a patient (Jane: 667-669).

Having a good relationship seemed to enable trust which appeared paramount in many of the interviews in accepting or not, the application of treatment pressures.

> It's definitely a threat off Charlie [housemate] yeah, it's a threat. Erm and I don't cross the line. So she's got the rules of the flat, so I do what she says. I think she's got my best interests at heart, 'cause I trust her (Caroline: 303-305).

Even when the experience of treatment pressure had been distressing, demeaning and harrowing, Amelia described how reparation in her relationships with clinicians was possible.

> And my consultant was brilliant too because he really got that I couldn't trust him <Hannah: yeah> and he really, he really worked to sort of rebuild that (Amelia: 744-775).

Time, effort and communication in order to rebuild trust seemed to be central to this process of reparation. Being known and treated as an individual person also seemed to be important in successful relationships between service-users and staff. These kinds of relationships seemed to ameliorate the negative effects of treatment pressure. Amelia described how having a good working relationship with her consultant eased the process of him forcibly treating her. She said his business-like interactional style suited her, because she's "very dispassionate when [she's] ill" (Amelia: 493). Jane similarly spoke of finding a crisis service that fit for her in terms of its ethos and expectations of service-users and facilitated her choice to live without medication.

> I think some women find it too intrusive and others not controlled, contained enough, but it, it definitely works for me, because they don't force you, if you have medication they will supervise your medication while you're there, keep it in their office and give it to you at certain times whatever, but they're very happy for me to be medication free (Jane: 554-558).

Similarly personal relationships were sometimes described as the context in which treatment pressure occurred, but also as sources of support which helped to alleviate the experiences.

> Just the support of my friends generally, you know I'm lucky I've got/ <Hannah: /support from friends?> I've got quite a lot of friends <Hannah: mm> that's been very helpful, you know (Susan: 391-393).

Caroline talked about the importance of personal relationships in the context of having a mental illness and how she complied with treatment pressures in order to maintain her accommodation and relationship with her housemate.

> I treasured that really 'cause you do lose friends when you're mentally ill. And erm, she stood by me so you know <Hannah: mm> erm and also I needed somewhere to live when I was pretty hopeless. Erm, so very kind <Hannah: mm> mm. So I didn't want

> to lose that. But I didn't like the idea of having to take the medication…but I decided that that was the way I was going to go and see what I could do (Caroline: 102-108).

Others talked about friends and family joining with services and exerting or supporting the exertion of treatment pressure. Jane and Susan described how this caused these personal relationships to deteriorate, and in some cases disintegrate; whereas Amelia described how a process of reparation was possible over time, through effort and communication.

> And I was very angry with my family, it took me a very long time to get over that feeling of anger, because I felt that they had been party to all of this <Hannah: right> you know I felt that, why didn't they stand in and stop it?...I'm not blaming … they trusted the doctors which I would have done too, and they were terrified …I talked it through with my husband afterwards and he told me his side of kind of what happened <Hannah: ok> and we drew to an understanding of what had gone on…and I think I also then, eventually talked to my parents, about it…so I think it was important to patch things up with, talk with my husband about it (Amelia: 744-773).

Perhaps being able to voice one's own thoughts and feelings about these experiences, as well as having more of an understanding of others' actions and their point of view, enabled the development of a narrative in which participants could start to make sense of what had happened and why.

3.2.4 A culturally bound experience

A number of participants talked about how their experience of treatment pressure occurred within a cultural context[14]. It seems that the construction of treatment

[14] Here I make use of the wide sense of the word culture – to include things such as ethnicity, social class and gender.

pressures and the effects were influenced by, and in parallel impacted upon participants' social category status.

A number of participants suggested how their gender and the gender of those exerting the treatment pressure might mediate these experiences. Some referred to gender in seeking to understand their experiences. Christine felt that her status as a woman had impacted on how the male psychiatrist assessing her had interpreted what she told him and how he subsequently viewed her.

> The doctor that interviewed me…we were talking about housework or something, and I said erm that, I had better things to do which I did (laughs) because I had all this other stuff <Hannah: mm> so the housework had to go down a bit. So erm, you know and he took that as being really bad, and he wrote down in the notes 'self-neglect' (laughs) you get judged if you're a woman and you don't have the place perfect. You know if you're a bloke it's not your fault (Christine: 746-754).

Perhaps this highlights an inherent sexism in society (Johnson, 1976) and how it can impact on the experiences of service-users because of the different gender norms about what is and isn't appropriate behaviour. As a result of this sexism it seems that women may be more readily pathologised than men in some psychiatric contexts. Many female participants also talked about how their gender impacted on how they experienced different types of treatment pressures, especially when they were exerted by a man. This seemed to add another dimension, served to increase the pressure experienced and made it feel more threatening.

> You think is some of this happening to me because I'm a woman <Hannah: mm> and they don't take me seriously because I'm a, you know, a woman. But I suppose less, less so <Hannah: mm> but more just the being, being you know constrained or restrained or whatever, by men, when you're a woman <Hannah: mm> is a, you know, is, I suppose it has a different dynamic <Hannah: sure> and it has been men, I mean, I think I've, in the very rare

> instance of a woman kind of saying something I just don't feel as threatened as you do, you do when it's a man, because at the end of the day they're you know, physically stronger (laughs) and quite, can be quite frightening really (Amelia: 677-685).

Some participants also used gender to make sense of their own and other service-users' reactions to treatment pressure. Both Christine and Jane talked about how they felt that they had complied more readily with treatment pressure than men would have.

> I think women are, more likely to comply <Hannah: mm> with requests and subtle pressures than men. I think my experience on psychiatric wards is that men tend to fight the system much more. Not necessarily in a constructive way, but you know, to assert their independence whereas my route to survival was very much to comply, particularly on the wards, you know (Jane: 446-451).

Jane also said she felt that "complicity allows survival" (456-457). Compliance might be sometimes used as a coping strategy, in order to avoid direct conflict with staff. This phrase seems to again indicate the powerlessness of service-users (as discussed earlier). Perhaps this sense of powerlessness is felt or voiced more readily by women, who are already granted less power than men within general society. Male participants more often talked about feeling angry with regards to the experience of treatment pressure, whilst women talked more frequently about feeling scared. Perhaps these reactions are related to dominant cultural stories about gender; e.g. what it is to be a woman or a man in the face of authority.

Kevin, who was of British Chinese ethnicity, talked about how his ethnicity in relationship to his care coordinator's ethnicity, impacted on his relationships with services and his ability to make a complaint about the way he had been treated.

> 'Cause my care coordinator is Chinese she's actually built up quite a good relationship with my mother <Hannah: right> and

> that's been clouding the issue about writing the complaint letter as well, 'cause I told her that, I told my mum look what, 'cause it's kind of like Chinese tradition and culture that the older generation you buy them presents and whatever, and I did tell her look her coming round to check up on me or whatever is actually her job…and then she was still like, you know inviting her out for lunch…I told her look, I'm even thinking of writing a complaint letter, erm, and then she just like said to me at the end, oh don't write a complaint letter, she's really nice to you (Kevin: 580-592).

Kevin later went on to talk about how his care coordinator would ring his mother to discuss his care-plan, giving another example of when social category status seemed to directly influence his experience of treatment and treatment pressure, and the processes through which this was exerted. Perhaps Kevin was experiencing a clash between western British cultural ideas about the importance of autonomy, and eastern Chinese cultural ideas about the significance of collectivism (e.g. Kashima et al., 1995).

Beyond gender and ethnicity, a number of participants also made reference to the role of social class in their accounts of treatment pressure. It seemed that their experiences of mental health services and associated treatment pressures, impacted on their social class status within society. Jane described feeling as though she lived "outside society" (182) whilst Susan described how being subject to a CTO felt like being designated to an underclass in which her human rights to refuse treatment were violated.

> You're an underclass because you don't have the rights that anyone else in the society has. You know the right to refuse treatment for a start (Susan: 185-187).

Lucy also made reference to social class when she discussed what impacted on her interactions with staff. She described how her status as a patient both separated her from, and overshadowed the status she had outside of the hospital ward. This seemed to imply that she felt far beneath a professional whom she would have felt 'on par' with in terms of status, prior to her admission.

> In a way it's a class thing as well…I felt the same thing, the sort of gulf between me and that woman, that therapist <Hannah: mm> when in my other life, I'd been a person working at that professional level <Hannah: mm> not at that job but at that position and level (Lucy: 508-515).

She went on to talk about staff treating her as though she had "lost [her] intelligence" (Lucy: 518) by underestimating her abilities in a game of scrabble. In giving an account of this incident she seemed to be describing experiences of feeling infantilised and patronised which were echoed in other interviews. These extracts seem to imply that having a patient status - in which one often experiences multiple treatment pressures - can impact on social status, perhaps by denigrating people into a certain group beneath others in which they feel both demeaned and disrespected. The 'feeling sub-human and powerless' sub-theme described earlier might contribute to this process also.

Having described part of the thematic analysis - how the experience of treatment pressures and their effects seemed to be constructed in the interviews; I will now move on to the second part by illustrating how participants constructed their management of these types of experiences.

3.2.5 Taking control: "it's fight, flight or comply"

In the process of interacting with and analysing the data I was moved by the devastation that experiencing treatment pressures caused in people's views of themselves, their views of and interactions within the world and in their relationships. However I was also struck by how each participant, in their own way, appeared to manage these often harrowing experiences. The processes of managing the experiences of treatment pressure described by all participants seemed to reflect different ways in which they had taken control. Through 'taking control' participants seemed to have been able to incorporate these often incredibly distressing experiences into narratives about themselves and social contexts. How participants took control appeared to be mediated by their

experiences of treatment pressure as well as their conceptualisations of themselves and services.

In Jane's account of her experiences of treatment pressure she talked about different ways of coping with them and said, "it's fight, flight or comply" (Jane: 456). There seemed to be four broad strategies of 'taking control' which participants discussed; three of which Jane mentioned. The four broad strategies were: 'fight', 'flight', 'comply' and 'seek information or support'. Which path of taking control people chose seemed to mediate how they interacted with services in the future and the effects that treatment pressure had on them. Participants also seemed to shift around in which strategy they used as their views and experiences changed. Many participants indicated learning to 'take control' as a process that took place over time, and described themselves as being "naïve" (Caroline: 214) when they first encountered services.

> I think I've obviously got a lot more experienced over time <Hannah: mm> So I've got much clearer views on what good treatment should be and how a patient should be treated (Lucy: 436-438).

Some participants' accounts seemed to portray their reaching a tipping point, prior to 'taking control'. Amelia, Jane and Mark all talked about experiencing moments when they were confronted with the need to take control of their situations in different ways. Amelia said that following an attempt to end her own life, she realised she needed to let others take control in order to stay alive. Jane described how the advent of the millennium made her decide between ending her life and stopping her medication. Similarly, on reaching 50-years-old Mark said he felt he needed to make a decision with regards to his medication:

> And I mean no one would like me to stop [taking medication] but I just thought at fifty, either I take this [medication] for the rest of my life or I stop, so I stopped, now I feel fine (Mark: 116-117).

As well as a process that occurred over time, taking control seemed to involve the sifting through and accommodation of multiple strong feelings with regards to

their experiences. All participants seemed to express a number of different and contradictory feelings in relation to the use of treatment pressures which appeared to influence the ways in which they took control of and managed their experiences of treatment pressure. Some appeared to move fluidly between supporting and contesting their use in different contexts, whilst others erred towards either agreeing with or opposing them. However all expressed ambivalence regarding their use at some point in the interview - both the processes involved and/or the outcome of treatment pressure. For some it seemed like they had to wrestle between opposing values and feelings in order to decide how to take control.

> It's a very strange thing because it's something which, it's without, you know without a doubt the most terrifying and traumatic experience of my life, and yet at the same time I, you know I think, I would sort of stand up in court to protect my human rights if you like to, my human rights to continue the, the sort of, for the right of other people to <Hannah: umm> to force me to be in hospital, to force me to accept treatment, that it should be entrenched in law (Amelia: 65-70).

Lucy similarly described great ambivalence and contradictory feelings in regards to her psychiatric medication and the pressure she felt to take it. She seemed to view her medication as the only thing that kept her going, and described clinging on to it almost for dear life, even though it seemed like part of her did not want to be kept safe and alive. This internal struggle seemed to be experienced by her as a strong pressure she exerted on herself to remain compliant with her medication in order to care for those whom she loved around her.

> I've been very aware certainly over the last year or so, there's only medication that's kept me safe so that's a personal pressure, to take that, even though I very much want to not be safe in a way…the only thing that was holding me on, that I could hold on to was the medication, that was all there was. So there's, there's a kind of pressure to carry on taking that even when things get

> that bad <Hannah: mm> which may sound contradictory (Lucy: 58-77).

Caroline seemed to acknowledge her difficult feelings with regards to treatment pressure exerted by her housemate, though also suggested that compliance enabled her to maintain part of her social support network. Her feelings regarding the treatment pressure and her social relationships appeared to be things (amongst others such as having paid employment and a roof over her head) which she considered in a cost-benefit analysis when deciding whether to comply or not. This process was similarly echoed in other interviews.

> I don't like this curfew of not being able to control my meds, I don't like that. But when I weigh it up it's worth it because it's a friend and I've got company (Caroline: 425-427).

3.2.5.1. Showing resistance

'Fighting' treatment pressures seemed to be indicated in the various ways participants described 'showing resistance', which appeared to have helped some participants to manage their experiences of treatment pressure and the associated effects.

> It is sink or swim and the people who recover the best are the ones that fight the system tooth and nail (Toby: 767-768).

Caroline spoke of resisting the treatment pressure to take medication because of the process of the treatment pressure itself - which she found unsupportive and unhelpful - but also of hiding her resistance from her care coordinator. She seemed to imply that she found a way to show her resistance by exerting an equal and opposite reaction to the treatment pressure she was subjected to.

> She was enforcing me to take it and I just didn't like the approach, erm and so I used to take it whilst she was there and then when I was left to my own means I didn't take it properly again/ <Hannah:

> /mm> Erm, so that can be a by-product of being enforced to take something, you rebel and go the other way (Caroline: 35-39).

Participants also described resistance through making a “protest” (Toby: 546) in different ways. Those that did appeared to be protesting against the unjust behaviours they had experienced. Toby spoke of stripping naked on the ward to protest his frustration with the staff. Christine described needing to make sure that services were held accountable for the unfair treatment she felt they had subjected her to. She seemed to portray her need for retribution for the personal injuries (both physical and non-physical) she has been subjected to; ‘taking control’ appeared to be her way of ensuring this would happen.

> I thought I must get my complaint out before my time runs out. So first of all I sat down, and I had one, only one arm to type with because they’d broken the other one. So I had to type with one hand my complaint…obviously it was tiring, and the emotional stress of having to do that, but I did not want them to get away with it. So even though my lawyer was suing them for the broken arm, I said to him it’s more than that, they did more to me than break my arm (Christine: 691-702).

Kevin similarly spoke of making a complaint when he felt staff members had said inappropriate things to him. He described experiencing a good outcome; the process of complaining helped to change his relationship with services for the better.

Some talked about resisting or fighting in a more active way - by joining service-user-run groups who campaign against the use of treatment pressure in the psychiatric system. They described how engaging with this process helped to empower them, which Christine talks about below. Perhaps ‘taking control’ through resistance enabled people to counter some of their feelings of powerlessness.

> I think if you fight back it makes you feel better…once I found out I thought I can’t not do anything, and I’m mad at them because

> the thing is I've got my life to live…I mean I really want to get things sorted out but I'm having to spend time doing this, and I don't want to do this, I want to say right that's the end of it, ok that was really bad, I'm now out of it, thank god, bye-bye. But once you've had your eyes opened, if you walk away, I'm walking away from all those people that are suffering now and I can't do it. The more I've read the more shocked I've become, I just think, these are people, they're doing this to people and they've got no voice and if they talk out, they'll get drugged more until they shut up (Christine: 873-891).

Christine again highlighted how she felt that life can never be the same again for her following her contact with mental health services. She also brings our attention to the strong, complex emotions surrounding the experience of treatment pressures, and how their enduring effects plus the powerlessness of service-users can spur and maintain a need to show resistance and to ensure retributive justice.

3.2.5.2 "Taking responsibility": going it alone

This sub-theme illustrates how some participants needed to escape (or 'flight') the people and/or systems applying treatment pressures to them. This 'taking control' strategy seemed to enable participants to liberate themselves from some of the distressing consequences of their experiences and the difficult relationships in which they occurred. Jane talked directly about needing to escape the psychiatric system in order to survive, and indicated the slow, laborious process that escaping entailed.

> Very quickly I realised that they, they were er, deceiving me and that they were completely untrustworthy and that actually if I was going to survive, the only way was to get the hell out. Which I did but it took me ten years (Jane: 119-122).

Jane, Mark and Toby all talked about managing, reducing or stopping their medications on their own in order to take control of their experiences of treatment pressure.

> I was experimenting with reducing my medication levels to see whether I needed you know high levels, you know I thought if I can get a good night's sleep on a low dosage. I mean it's called self-management you know…I think self-management is a good idea because you're taking responsibility" (Toby: 945-949).

Undertaking this process alone seemed necessary in order to escape the controlling psychiatric system, in which all felt unable to voice and enact their own decisions without potential drastic consequences.

> Hannah: With the coming off medication <Jane: mm> erm, and you said you had to do that kind of unbeknownst to anyone else really <Jane: yeah> what, what was that about, why was it, why were you unable to say this is what I want to do/
> Jane: /Oh because you know they, there could have been, I could have been sectioned and that's that's bottom line, er but, you know that's the worst case scenario, I could have been sectioned, detained in hospital, forcibly medicated until I agreed to comply, which you know, had happened several times before in various different experiences and I wasn't going to go there again (Jane: 339-346).

3.2.5.3 "Harnessing coercion"

This sub-theme describes the third strategy of managing treatment pressures; complying with, or in some way choosing them.

The horrific and disturbing nature of Amelia's descriptions of treatment pressure was striking, yet she also seemed to describe something that kept her returning to services. She appeared to use "harnessing coercion" (712) as a way of 'taking control' of her experiences and managing them. In doing this Amelia illustrated

how she “came full circle” (449) and had been able to put herself back in the driving seat if you like – a position in which she was able to incorporate her experiences into her understanding of the world, herself, those around her and the relationships between. She relayed her process of ‘taking control’ as co-writing an advanced directive with her psychiatrist and said, “I sign myself over effectively to my consultant” (460) at times when she was considered to be unwell. In this document Amelia said she specified that others should not listen to any arguments or protests she gave until she had received the treatments her consultant saw fit. In other words she “effectively scuppered” herself (495). This handing over of control to others seemed to be supported by her understanding of herself as having a malfunctioning brain; “the way I see it there’s something wrong, you know there’s something that happens in my brain” (965-966). Amelia went on to say how this process of “harnessing coercion” had eased the effects of the experiences of treatment pressure, both within herself and in her relationships with others.

> Even though it’s coercion when it actually happens, somehow if you know, if you sort of know that you’ve kind of anticipated it to the point that you set it down in writing yourself <Hannah: mm> erm, it just feels, even if not at the time, afterwards certainly, because a lot of it’s the aftermath, you know, dealing with the aftermath and actually it’s not you know (small laugh) it’s a much better process dealing with the aftermath when actually you had kind of almost, pretty much condoned the whole thing yourself (Amelia: 838-844).

Amelia’s understanding of herself as in need of others to “take charge” (967) at times was echoed in other interviews. Other participants also seemed at various points to propose a biological understanding of their distress, and understood themselves as having an illness and therefore requiring others taking control at times when they were most unwell. Some participants appeared to define themselves as not being in a position to make treatment decisions at times when they felt very distressed. They seemed to feel that it was good that services,

sometimes with the support of family members, stepped in to take control and make treatment decisions on their behalf.

> Hannah: And do you feel it was talked to you, the kind of, the process was talked through and and the decision/ [about ECT]
> Lucy: /I think it was talked through, not necessarily with me, I don't think it was possible to talk things through with me rationally then anyway. Erm, so I think it was certainly considered quite carefully <Hannah: mm> and in light of whatever Michael [husband] had to say (Lucy: 428-432).

Both Lucy and Amelia seemed to describe the life-saving nature of treatment pressures.

> I'm almost certain that if I hadn't had someone watching me, you know I would have, I would have stabbed myself… so, you know if I hadn't of had that piece of paper [advanced directive] if he hadn't of said yeah I know you don't want someone watching you but you have to have someone watching you (Amelia: 924-934).

Their views - which suggested that without the mental health system and those working within it being permitted to exert treatment pressures, they would be dead - appeared to be in stark contrast to a number of the other interviews. A number of other participants also seemed to 'take control' and manage their experiences of treatment pressure by complying with them but in different ways. Susan described complying in order to secure her discharge from the ward, whilst Christine talked about pretending to comply in order to regain some form of control (i.e. over her medication).

> You feel that, you know, the only way to get out is to cooperate, so in order to get out you cooperate with everything (Susan: 148-149).

> Luckily I had control of the pills because I picked them up, they were going to pick them up and then they would have stood there watching me take them <Hannah: mm> but luckily I'd gone back to

> the hospital and I'd picked up the pills myself, so I was in control of them. So I wasn't taking them, just in case they checked, I was popping them out regularly and putting them somewhere (laughs) <Hannah: mm> somewhere else. So I could say look, the packet's empty (Christine: 408-414).

The strategy of complying also seemed to be used by participants when they described choosing the lesser of two evils between two different treatment pressures.

> I went along with the P.R.N. [15] because I mean I knew, from past experience, that if you say no to P.R.N. they will restrain you and inject you, simple as that (Toby: 211-212).

In all of the above extracts it seems that complying or choosing certain treatment pressures enabled people to maintain some sense of autonomy in the context of seemingly very difficult circumstances. This increased autonomy then perhaps served to empower them, in terms of both their own identity and their relationships with services.

3.2.5.4 Seeking information and support

The final strategy for managing the experiences of treatment pressure and 'taking control' that I constructed from the interview data was 'seeking information and support'. Participants described seeking further information about the treatments they were being pressured to take and seeking support from other sources (e.g. service-user groups or other professionals who offered alternative forms of help).

Many participants described services as not providing them with sufficient information with regards to what was happening to them and the treatments they were being given (such as side effects). As a way of managing their experienced exclusion from treatment decisions, some participants seemed to take it upon

[15] Pro re nata medication which is used as needed rather than scheduled.

themselves to find out information about the treatments offered, and alternatives that were available. Jane described the importance of finding what fits for each individual and how the process of doing this for oneself can increase a sense of power and control in a context where one can feel unheard and has decisions made on one's behalf.

> I think, the biggest, the biggest form of empowerment than anyone can, can give themselves who is trapped in a psychiatric erm, dead end, is to look, research, try and understand what they're giving you, try and find out what alternatives there are, and keep yourself as an ongoing experiment, because they're treating you like an ongoing experiment, and if you're in control of your own ongoing experiment then you've got a hell of a lot better chance of getting the right answers for you, 'cause they're going to be different for you than they are for anyone else that you come across. It doesn't matter who you are, you're going to have your own unique combination of answers (Jane: 721-729).

In the above extract Jane speaks of individuality which was described as lost in the "they don't know me" sub-theme. Perhaps seeking information and support helps to counter this process. Many participants described seeking peer support from people they perceived as having similar views to their own in service-user groups. This joining with others appeared to help them to feel less alone and powerless, in both their struggles with treatment pressure and distress more generally. As well as having an effect on participants' sense of isolation, seeking information and different types of support seemed to alleviate the traumatic after-effects described in relation to the experiences of treatment pressure.

> I mean the way that I think, I've been thinking this for ages, you know that basically it's all wrong and they shouldn't be doing it. Erm, it's much easier erm, to hold those ideas when erm, when you've got friends who feel the same way (Susan: 462-465).

Some spoke about seeking alternative sources of help to alleviate the distress associated with their experience of treatment pressure.

> I did hypnotherapy and he was really helpful <Hannah: ok> with the kind of you know, hypnosis to sort of get over, you know to try and feel less affected by traumatic memories…I didn't feel as terrified by the memories as I had done (Amelia: 817-821).

Overall the strategies that participants appeared to use in order to 'take control' and manage their experiences of treatment pressure seemed to: enable people to make sense of them; place them within a coherent narrative; moderate the impact these experiences had on them; and ameliorate their relationship with the person exerting the pressure and services in more general.

3.3 Summary

In this chapter I have attempted to explicate the thematic analysis I constructed through my interactions with both participants and the data - of which the overarching theme was, 'experiencing and managing treatment pressure' - and to illustrate it using themes, sub-themes and data extracts.

Chapter 4: Discussion

4.1 Overview of chapter

In this chapter I will discuss the thematic analysis in the context of the research questions, the literature outlined in the introduction and other relevant literature. I shall then go on to evaluate the quality of the study and discuss its limitations. Finally research and clinical implications will be considered.

4.2 Research questions

4.2.1 What range of treatment pressures do service-users experience?

Participant accounts of their experiences of treatment pressure involved the nature of the treatment pressure itself, the relationship with the person exerting the pressure, and the individual's social category status (e.g. gender, class). Experiences of many varied treatment pressures, in both community and psychiatric hospital wards contexts, were described corroborating the high prevalence rates reported in much of the existing research[16] (Kjellin et al., 2004; Monahan et al., 2005; Newton-Howes and Stanley, 2012). Many of the reported treatment pressures occurred within a psychiatric setting and involved coerced medication, deprivation of liberty, or a limited choice/no choice of interventions. As far as I am aware, having no choice or a limited choice, with regards to treatment options, has not been discussed as a variant of treatment pressure before. Similarly, neither have being denied treatment, or having services removed prematurely i.e. being pressured to live without treatment. These findings are especially relevant given the current context of financial restraint and service cuts which has resulted in reduced availability of treatments, with the emphasis placed on the provision of cost-effective therapies such as medication

[16] As outlined in the introduction, the majority of the literature referenced concerns the narrower term 'coercion'. To reflect the subject of this study, and for clarity I will use the term 'treatment pressure' in this chapter.

or time-limited, structured talking therapies (Mental Health Foundation, 2012). It also seems to contrast with the current NHS ethos of 'choice' with regards to one's healthcare', reflected in the '2013/14 Choice Framework' published by the DoH (2013).

Other treatment pressures were described as occurring within a personal context; exerted by family and/or friends, sometimes in conjunction with psychiatric services. The process of feeling dehumanised by others (clinicians, services more broadly and/or family/friends) seemed to be of particular importance in the experience of treatment pressure. Feeling dehumanised encompassed feeling 'othered', pathologised, having less power, and treated as a 'patient' rather than a person; all of which served to exacerbate the experience of pressure for participants. These findings are similar to the ones described by Newton-Howes and Mullen (2011) in their review of qualitative studies. Therefore treating service-users as unique human beings, rather than one-amongst-many or a 'case' of a 'mental illness', seem to be important in reducing their experiences of treatment pressure (and perhaps improving their mental health also).

Participants' experiences of feeling dehumanised also echoed the findings of the seminal research by Rosenhan, 'On being sane in insane places' (1973). Rosenhan and several other researchers set up a study in which they were admitted to psychiatric units after presenting themselves to services claiming they were hearing voices saying things such as "empty" and "thud" (rather than 'hallucinations' commonly considered to be associated with 'psychosis' e.g. about wanting to die/harm others). The study reported on the harsh treatment subjected to inpatients of the wards and concluded that depersonalisation occurred through staff fear and avoidance of service-users. For example staff were reported to keep to themselves, only engaging with patients for caretaking purposes, and have reduced eye and verbal contact with them. One patient was beaten in the presence of others, seemingly for having approached an attendant and telling him "I like you". Rosenhan (1973) stated, "neither anecdotal nor 'hard' data can convey the overwhelming sense of powerlessness which invades the individual as he is continually exposed to the depersonalization of the psychiatric hospital" (p.394-395).

Once admitted to hospital the “pseudo-patients” behaved as they normally would. Despite this, Rosenhan argued, their behaviours were viewed through the lens of ‘mental illness’, and labelled as part of their pathologies. These findings illustrate diagnostic overshadowing; in which all behaviours are viewed as ‘symptoms’. These ‘symptoms’ are then considered proof of the need for further treatment in the context of a psychiatric ward. People can therefore become locked into mental health services through self-fulfilling diagnoses. A similar process of pathologisation was described by participants in this study. For example Toby said he thought his refusal to comply with medication was perceived by staff as evidence for the symptom ‘lack of insight’.

Feeling treated like a human being has been suggested by Katsakou and Priebe (2007) as minimising the distress involved in compulsory hospitalisation and treatment. The findings of this study indicate that in the context of both an inpatient ward and the community, and for people of both formal and informal status; having consistent relationships with people involved in decisions regarding their treatment can help to create a context in which service-users feel identified as an individual. The participants of this study described how consistent relationships fostered the development of trust and gave them faith that the other person had their best interests at heart. This finding helps elaborate upon why the therapeutic relationship is important in the experience of treatment pressures (Sheehan, 2009) and the processes through which it can alleviate the distress caused.

As described in the introduction (section 1.8) a number of studies have reported that gender affects the experience of coercion, though the results are mixed. A number of female participants in this study spoke of how their gender affected how they were treated by clinicians. Some women said they felt they were pathologised more readily e.g. Christine spoke about how the doctor noted her ‘self-neglect’, when she told him she had fallen behind with the housework because she had been busy. She said she didn’t think this would have happened if she were a man. Others discussed how they experienced the actual treatment pressure. For example, being restrained by a male clinician was said to be experienced as more threatening. A number of female participants also said that

they felt women were more likely to comply with treatment pressures. These findings help us to form hypotheses about how women's less privileged position in society (Johnson, 1976) and the context of gender might impact on how treatment pressures are experienced.

4.2.2 What are the effects of experiencing treatment pressure on service-users?

Participants talked about how treatment pressures impacted on both themselves and their relationships with others. The personal impact described encompassed both emotional and cognitive effects. Fear and anger were frequently mentioned as emotional reactions, whilst the cognitive effects described included having one's worldview and self-identity negatively impacted upon. These are reminiscent of common reactions to trauma described in the literature regarding posttraumatic stress, supporting the evidence that the experience of severe treatment pressure (e.g. compulsory medication or hospitalisation) can be traumatic for those that experience them (Morrison et al., 1999; Priebe, Broker and Gunkel, 1998). Janoff-Bulman (1992) proposed that traumatic events shatter three fundamental assumptions people hold: the world is benevolent; the world is meaningful; and the self is worthy. The cognitive reactions described by some of the participants in relation to their experiences of treatment pressure seem similar to these. This further illustrates the traumatic nature of these experiences, and the serious impact they can have on the lives of whom they are subjected. Janoff-Bulman (1992) also suggested that cognitive adjustment necessarily ensues following traumatic experiences, which is perhaps indicated by the different strategies described by the participants of this study used to 'take control' of their experiences of treatment pressure. These are discussed further in section 4.2.3.

The impact of treatment pressures on both personal relationships and relationships with clinicians/services was also described. Some participants discussed avoiding services, or at least interacting with them in a less open way (e.g. pretending to take medication, or avoiding speaking directly about how they were feeling in themselves); whereas others spoke of adjusting their relationships with clinicians (e.g. through complying with treatment pressures or openly resisting them). These results reflect the variation in findings regarding the impact

of treatment pressure on future engagement with services, outlined in the literature review (Bindman et al., 2005; O'Donoghue et al., 2011).

Personal relationships were similarly talked about as being affected, especially when a family member or friend exerted the pressure. However, some participants felt that the closer, more trusting nature of personal relationships (rather than those with clinicians) made it easier to accept the treatment pressure, or easier for the reparation of the experienced rupture in the relationship to occur.

4.2.3 What processes mediate the experience of treatment pressures and how are they managed?

The processes surrounding the experience and negotiation of treatment pressures were described by participants as the different means by which they managed and responded to their experiences, and also in how they made sense of them. As portrayed in the thematic analysis, participants reacted to their experiences of treatment pressure by taking control of them in different ways, including: fighting them; escaping them or limiting their contact with services to reduce their experience of them; finding ways that enabled them to comply with them; and seeking more information regarding treatments and/or alternative sources of support. These means of reacting to treatment pressure appeared to manage both the effects on the individual and on their relationships with others. Many similar processes have been written about previously, though have not been brought together in a cohesive way.

Participants' descriptions of compliance with treatment pressures echoed the findings of the study by Gilburt, Rose and Slade (2008) in which reactions to psychiatric hospital admission included "playing the game" and "following the rules". In comparison, 'fighting' the system sometimes seemed to involve becoming an activist against the use of treatment pressures, which is reminiscent of the finding that compulsory inpatient treatment served as "motivation for political engagement" (Sibitz et al., 2011). Masson (1988) similarly wrote about how actively opposing the psychiatric system can serve to remedy the dehumanisation service-users experience; "politicizing oneself by joining with

other survivors in political actions is an excellent antidote to the powerlessness that psychiatry induces in its subjects...finally, becoming informed, the hard way, by active investigation is still the best way of exposing the truth" (p.319). The latter part of this quote appears to refer to another process of managing experiences of treatment pressure described in the thematic analysis; seeking further information in order to be able to make more informed decisions with regards to treatments.

As mentioned, seeking alternative avenues of support such as service-user groups was described by some of the participants as a way of managing their experiences. 'Speak Out Against Psychiatry' (SOAP) is one such group. SOAP recently wrote a piece on 'How to escape from a psychiatric ward' (2013). The article describes three strategies to accomplish this: "running away", "playing the game" and "going for a tribunal". "Playing the game" involved pretending to believe one has an illness and that medication helps; this strategy seems to reflect the 'compliance' strategy that some of the participants in this study described. The view offered by other participants - who proposed the need to 'escape' the system - is suggestive of the article's final statement, "recovery begins with noncompliance" (SOAP, 2013).

The processes surrounding the experience of treatment pressures also appear to have involved the need to make sense of their occurrence. This encompassed defining the behaviour of staff, which was often described by participants as incomprehensible or explained in terms of blindly following rules. At this point in the analysis I was reminded of the work conducted by Menzies-Lyth (1960) in general health hospitals; which concerned the institutional defences used by nursing staff to protect themselves from the anxiety they felt in regards to their work. Perhaps the participants in this study were describing the use of similar coping mechanisms by psychiatric staff. Distancing themselves from service-users or following orders might have enabled them to fulfil their job description, administering treatments that service-users frequently opposed.

Rosenhan (1973) similarly discussed how the behaviour of staff in the study he conducted was attributable to the context of the system and the expectations

placed upon them within it. He concluded, “their [staff] perceptions and behaviour were controlled by the situation, rather than being motivated by a malicious disposition. In a more benign environment, one that was less attached to global diagnosis, their behaviours and judgements might have been more benign and effective” (p.257).

In their accounts of why staff used treatment pressures, participants appeared to make reference to an increasing preoccupation with risk - both in mental health services and society more generally (for a discussion of this see e.g. Harper, 2004). Clinicians were described as using treatment pressures in a way that was often seen to indicate defensive practice. For example Christine expressed that she thought professionals were unwilling to reduce or stop medication for fear that a service-user would kill themselves or others. The dominance of fear in the construction and running of mental health services is discussed by Laurance, whose book ‘Pure madness: How fear drives the mental health system’ stated:

> Professionals say that it is only in the last five years that the pressure from a government and public averse to risk and bent on pinning blame when things go wrong has produced a culture of containment in the mental health services seen in rising detention, increasing use of medication, locked wards and growing dissatisfaction among the users of services. While public safety and the avoidance of risk drives the service, fuelled by fear and political opportunism, the demand from the people who use the service for more involvement and control, more ‘ownership’ of their problems and treatment, is rising to a crescendo. The biggest challenge in the last decade has been the growing protest from people with mental health problems who use the services. There is enormous dissatisfaction with the treatment offered, with the emphasis on risk reduction and containment and the narrow focus on medication. They dislike the heavy doses of anti-psychotic and sedative drugs with their unpleasant side effects, and a growing number reject the biomedical approach which defines their problems as illnesses to be

> medicated, rather than social or psychological difficulties to be resolved with other kinds of help (Laurance, 2003, p.xix).

This extract not only describes defensive practice, but also the growing unrest toward the use of treatment pressures; the limited range of treatments available; the view of service-users and services the use of treatment pressure supports; and their desire to take a stand against them. These issues were similarly described by the participants in this study, in how they made sense of their experiences and highlighted what they thought needed to be changed.

4.3 Evaluation of quality

I will draw upon the work of Spencer and Ritchie (2012) to evaluate the quality of this study. As outlined in the methodology chapter, these authors have identified three widely recognised quality principles that qualitative research should be concerned with: "the contribution of the research, the credibility it holds and the rigour of its conduct" (Spencer and Ritchie, 2012, p.229).

4.3.1 Contribution

How has knowledge/understanding been extended?

One of the aims of this study was to construct an analysis of service-users' experiences of a range of treatment pressures, which to my knowledge there is no precedent. It was hoped that with a clearer understanding of the experience of treatment pressures the processes involved in these and the impact of them on participants' lives; ways of reducing their use, or ameliorating their potential negative effects could be developed. The study has resulted in a thematic analysis of the experience and management of treatment pressures which does indicate several ways in which service provision could be altered to minimise the experience or impact of treatment pressures (discussed in section 4.7 below). Most of the participants however, had experienced being sectioned under the MHA (1983), and spoke for the main part about these experiences. Therefore the

study did not cover as broad a range of potential treatment pressures as I would have hoped.

How well is the basis for drawing wider inference explained?

Ten participants are a poor representation of all mental health service-users. However, 'analytic generalisability' (Yin, 1994) refers to how case studies can give rise to theoretical insights and therefore may be generally applicable. I have tried to explain the 'analytic generalisability' of the results by discussing them in the context of the existing literature and suggesting research and clinical implications.

4.3.2 Credibility

How does the evidence support the findings?

In the analysis chapter I have tried to provide a coherent, thematic analysis and provide clear examples of themes and sub-themes using data extracts. I have also tried to demonstrate how my interpretation is grounded in the data, by including examples of line-by-line and focused coding, as well as the process of developing a theme from the coding process using a memo (see appendices I, J, K).

What forms of validation have been attempted?

Throughout its construction the analysis was reviewed by an 'additional analytical auditor' (the director of studies of this research) in order to check for errors, inconsistencies and/or overstatements (Elliott et al., 1999). Due to time constraints I was not able to liaise with the participants in order to receive feedback about the credibility of the findings for them. I plan to do this following thesis submission as all participants were keen to be informed of the results. I will respond to their feedback and make necessary alterations to the analysis in the event of preparing this study for publication.

How plausible are the findings?

I have provided an overview of the existing body of literature concerning treatment pressure and attempted to discuss this study in relation to it. Throughout this report I have attempted to provide a clear, transparent and reflexive documentation of the research process.

4.3.3 Rigour

A brief discussion of the rigour of this study was presented in the methodology chapter, though I shall briefly return to it here. Reflexivity of the research process is discussed in section 4.4 below.

How thoroughly was the analysis carried out?

Throughout I have aimed to conduct a thorough thematic analysis and have tried to be transparent in the processes I have used to attempt to achieve this. During the analysis process I have attempted to portray the complexity of participants' experiences and the meaning they ascribe to them by using their language and terms wherever possible. Where necessary, in the data extracts provided I have attempted to show which question/comment of mine the participants' words followed so as to preserve the context of the data.

How clear and coherent is the reporting?

I have tried to be clear and coherent throughout this report. As explained above, I will produce a summary of the findings for all participants following submission of this thesis.

4.4 Reflexivity

Reflexivity is an important criterion for the evaluation of research which adopts a contextual constructionist epistemological position (Willig, 2008). Throughout the process of this study I have tried to maintain reflexivity in order to show how both

participants' and my own accounts are grounded in their context. I will now discuss pertinent aspects of both personal and epistemological reflexivity.

4.4.1 Personal

My knowledge, characteristics, experiences and values will all have influenced the processes of recruitment, data generation and analysis. By writing a reflective diary, writing memos (see appendices B and K) and having conversations in supervision and with other colleagues/peers, I sought to remain aware of the ways I was influencing the progression of this study through my own ideas and assumptions, and the participants' ideas and assumptions about me.

I have reflected upon whether female participants felt more at ease with discussing the role of gender in their experiences with me as I am also a woman. Similarly my gender and awareness of gender inequality issues may have meant that I paid more attention to the gender context of women than of men. Female participants did tend to divulge more detail about the intricacies of their experiences of treatment pressures and the effects of these on their lives. Perhaps this was influenced by my own gender or it might reflect the wider context - that women felt more affected by their experiences due to their lower status in society in comparison to men (Johnson, 1976).

My pre-existing ideas about treatment pressures (outlined in the methodology chapter) will have influenced how I engaged in the process of my conversations with participants. For example I found it harder to hear participant accounts of treatment pressures, such as the administration of ECT as saving their lives. However, I tried to be open-minded during each of the interviews and listen attentively to the views of those I was talking to. I also used the reflective journal and conversations with my peers to process my own thoughts and feelings.

Participants appeared to make sense of my interest in this topic in different ways. For example Christine seemed to view me as being against the use of treatment pressure. At the end of the interview she said, "It's great you're doing this research – we need to stop coercion". This apparent assumption she made about me perhaps helps to explain her openness in the interview about experiences

she had found very distressing. Caroline similarly put me in a position of moral authority and asked for my opinion regarding the treatment pressure she talked about relating to her flatmate. I was reticent to offer my evaluation, emphasising my interest in her own ideas and how she managed these through her interactions with both her flatmate and psychiatric team.

4.4.2 Epistemological

The assumptions entailed in methods used by this study will have inevitably impacted on the findings.

Data collection methods

Email was used as the method of recruiting participants. In hindsight this was perhaps not the best process of recruitment to use. Using email restricted who was able to participate in the study to those who were computer literate and had access to email. By not meeting potential participants face-to-face, I was unable to discuss the study and concerns regarding it with more hesitant people. One study reported that initial refusal to participate in research studies was higher in African Caribbean participants (Jackson et al., 2004). Given both this and that black and black mixed ethnic groups are more likely to experience coercive treatments (Race Equality Foundation, 2007), I should have perhaps visited mental health service user groups (particularly those aimed at Black and Minority ethnic groups) in order to recruit a more representative sample. In order “to ensure research participation is accessible to all, researchers must employ flexible recruitment methods that permit adaptation to specific needs arising out of health status, level of involvement with services, culture and socioeconomic status” (p. 132, Rugkasa and Canvin, 2011).

The nature of one-to-one interviews can sometimes feel quite intense. Some participants talked less about the emotional impact of their experiences. Perhaps if I had used personal video diaries or the use of written accounts, participants might have felt more at ease with discussing these elements. Two participants did send me narratives regarding their experiences they had written previously

which were very moving to read. A different method of data collection could have incorporated these into the analysis.

Potter and Hepburn (2005) argued that the removal of interviewer from the data is problematic because it fails to attend to the interactional process of data generation. In keeping with the epistemological stance of this study, I have tried where possible to include my own questions or comments in the data extracts provided. The extracts have had to be highly edited to fit within this report, and I recognise that this does not fully preserve the interactional nature of data generation. This, as well as transcription of the interviews and consequential loss of non-verbal communication, might have limited the analysis (Opie, 1992).

Data analysis methods

I was struck during a number of interviews by how the experience of treatment pressures interrupted participants' life narratives. It seemed as though many had found ways of incorporating these experiences into their life stories since. Narrative analysis would have enabled me to explore these ideas in more depth. Similarly a discourse analysis could have explored how participants drew on wider discursive practices in conversations, and the implications of these for their subjectivity and experience.

4.5 Limitations

The sample of this study entails a number of limitations. Only two participants had no experience of being sectioned under the MHA (1983), and all had been inpatients in a psychiatric ward at some point in their lives. Participants tended to describe their most extreme experiences of treatment pressure, such as forced medication or being restrained. Consequently, despite repeatedly asking people to discuss the whole range of treatment pressures they had experienced, most of the interviews concerned coercive experiences, many of which occurred on inpatient psychiatric wards. This is perhaps unsurprising given their seemingly

traumatic effects. This did mean however that fewer accounts of subtle treatment pressures, or treatment pressures in a community context were given.

The *Count Me In* census (2010) reported that the detention of white British males under the MHA (1983) was 16 per cent lower than average, whilst it was higher than average for all other groups: the white/black Caribbean group was 77 per cent higher than average; the black Caribbean group 100 per cent higher; the black African group 27 per cent higher; and the black other group 52 per cent higher. My sample however had no one of black or black mixed ethnicity and therefore is not representative of psychiatric inpatient services, especially of those in London where the research took place. Future research should aim to explore the experiences of treatment pressures amongst black and black/mixed minority ethnic groups in particular, given that these groups are over-represented in psychiatric inpatient services and are more frequently subjected to harsher treatment, including coercive measures (Race Equality Foundation, 2007).

In my descriptions of 'emotional and cognitive effects' of treatment pressures I acknowledge that I am potentially reifying constructs or concepts of emotions/cognitions, with the implication that they are 'real' aspects of internal experience. Although this is problematic Sampson (1993) acknowledged the difficulties inherent in describing aspects of experience without 'essentialising' them (where essentialism assumes that something is detectible and objective). It was my intention in this study to explore how participants' experiences are constructed within both their inter- and intra- personal contexts, rather than to reify constructs such as emotional or cognitive effects. This is also less problematic given the contextualist epistemological stance taken in this study.

4.6 Research implications

As discussed in the previous section, the experiences of treatment pressure amongst Black and Minority Ethnic groups could be explored using purposive sampling. This is especially important considering the finding that those from a minority ethnic group are more likely to receive compulsory treatment than their

White British counterparts (Care Quality Commission, 2012) as discussed in the opening chapter. Less restrictive recruitment methods could be used in order to achieve this (e.g. visiting Black and Minority Ethnic service user groups to inform potential participants about the research). Purposive sampling could similarly be conducted with non-inpatients in order to explore a wider range of treatment pressures.

Critics have suggested that coercion occurs in the context of talking therapies (Smail, 2003) yet this is a neglected area in the existing literature. Two participants in this study spoke of experiencing treatment pressures in relation to talking therapies in the context of therapeutic communities. Although they, and many other participants, also said they wanted increased access to a range of talking therapies. Pressure in the context of therapy could occur in different ways because of the often quite intense relationship it entails. Future research could consider using quantitative measures initially to ascertain prevalence rates. Qualitative research could then explore the processes involved in more depth.

4.7 Clinical implications

4.7.1 Clinical psychology

The findings of this study raise fundamental ethical questions for clinical psychologists and their participation in systems that employ coercive methods. Gelsthorpe (1999) highlighted that “clinical psychologists appear to find working in severe mental illness services extremely difficult” (p.16). He suggested a number of reasons why this is, including; their seeing that the mental health system can be damaging to service-users, and the tendency to disagree with the dominant, medicalised conceptualisations of mental distress. Given this and the reliance of services on treatment pressures (described both in this study and other research) it seems relevant for clinical psychologists (both individually and collectively as a profession) to consider the ethical issues associated with participating in these systems. Further reflection is needed particularly on the scope for both passive compliance and resistance in working within mental health

services. Since the 2007 amendments to the MHA (1983) clinical psychologists can train and be appointed as Approved Mental Health Professionals with the power to section service-users. Has the profession therefore become more compliant with the use of treatment pressures and coercion? Gelsthorpe (1999) argued that the *raison d'étre* of multidisciplinary teams is to disagree, debate and argue with one another. Perhaps it is time that clinical psychologists challenge more readily the status quo of mental health services, the medicalisation of distress and consequent use of treatment pressures. The recent statement released by the Division of Clinical Psychology on the fifth edition of the DSM (American Psychiatric Association) may indicate that the profession is starting to raise their objections and discomfort more openly.

As an alternative to inpatient psychiatric wards (rather than treatment pressures in general) clinical psychologists could promote the culture and model used within 'Star Wards'. These wards focus on, amongst other things: the provision of high quality information for service-users, fostering of good relationships between service-users and staff; avoidance of conflict; a holistic approach to treatment; the importance of the physical ward environment; and what is going well in services. Given the finding of this study, the ethos of Star Wards and the ways in which it is implemented would appear to reduce the experience of treatment pressures for service-users in inpatient settings. A report by Simpson and Janner (2010) looked at the impact of Star Wards and reported: improvements in staff morale, patient satisfaction and quality of care; a 71 per cent reduction in aggression on the ward; reduced staff sickness; and a reduction in the need to use special observation methods.

As therapists, clinical psychologists can also provide interventions such as narrative therapy (White and Epston, 1990) to help service-users overcome the sometimes traumatic nature of treatment pressure. As researchers they can continue to contribute to the body of literature concerning this area by developing methods to reduce both recourse to coercion and its negative after-effects.

4.7.2 Service level

The importance of the provision of information regarding treatments was described by many participants. This is central if service-users are to make informed decisions with regards to the treatments they are offered by mental health services. One important aspect described by participants was the need for information to be provided with a level of detail that was both informative and understandable, and delivered via an appropriate medium. This highlights the importance of working with the individual rather than treating each person as part of a homogenous group of 'patients', which was another theme that ran through the study. This could perhaps be achieved by making available a range of different sources of information (e.g. 'You Tube' videos, peer group meetings, magazines etc.) and encouraging the development of therapeutic relationships based on open discussion and transparency with regards to the process of treatment decisions.

The high use of bank (temporary) staff on psychiatric wards limits the formation of consistent relationships between service-users and staff. The constructed thematic analysis suggests that the recruitment of permanent staff in these contexts might help to reduce service-users' experiences of treatment pressure.

4.7.3 Intervention

The use of advanced directives was mentioned by two participants and has been described as reconciling the ethical dilemmas posed by non-consensual treatment in terms of a person's autonomy (Halpern and Szmukler, 1997). Making the use of advanced directives a statutory requirement within mental health services would offer service-users some control over their treatment. The thematic analysis constructed suggests this is important in the experience and management of treatment pressure. Co-creating an advanced directive with one's clinicians would also entail being given both individualised and sufficient information regarding the treatment options (see section 4.7.2). It would also enable a forum for having one's views heard and respected, both of which were described by participants as needed improvements within mental health services.

The thematic analysis suggests that having more choice with regards to treatment options would similarly serve to reduce the experience of treatment pressures. As Freyenhagen and O'Shea (2013) suggested, "every effort should be made to avoid interference with liberty – often creative thinking about treatment or care provisions can help here instead of accepting a narrow set of alternatives (such as treatment against refusal or no treatment at all)" (p.68).

4.7.4 Policy level

As outlined in the introduction (section 1.6.1) many of the recommendations made by the Expert Committee (1999) were removed or diluted in the 2007 amendments of the MHA (1983) (Grounds, 2001). The emotive accounts of experiences of treatment pressure and their impact on people's lives described by the participants of this study suggest that in the future, suggestions such as these should not be so readily disregarded, so as to ensure the development of more ethical service provision.

References

Allport, G.W. (1963). *Pattern and growth in personality.* London: Holt, Rinehart and Winston.

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders (4th edn).* Washington DC.

Appelbaum, P. S. & Le Melle, S. (2008). Techniques used by assertive community treatment (act) teams to encourage adherence: Patient and staff perceptions. *Community Mental Health Journal, 44*(6), 459-464.

Atkinson, P. & Silverman, D. (1997). Kundera's immortality: the interview society and the invention of the self. *Qualitative Inquiry, 3*(3), 304-325.

Banister, P., Burman, E., Parker, I., Taylor, B. & Tindall, C. (1994). *Qualitative methods in psychology: A research guide.* Buckingham: Open University Press.

Barber, P., Brown, R. & Martin, D. (2009). *Mental Health Law in England and Wales: Guide for Approved Mental Health Professionals including the text of the Mental Health Act, 2007.* Exeter: Learning Matters.

Bennett, N.S., Lidz, C.W., Monahan, J. & Mulvey, E.P. (1993). Inclusion, motivation, and good faith: The morality of coercion in mental hospital admission. *Behavioral Sciences & the Law, 11*(3), 295-306.

Best, G. (1997). *War and law since 1945.* Oxford: Clarendon Press.

Beveridge, A. (1998). Psychology of compulsory detention. *Psychiatric Bulletin, 22*, 115–117.

Bhui, K. Stansfeld, S., Hull, S., Priebe, S., Mole, F. & Feder, G. (2003). Ethnic variations in pathways to and use of specialist mental health services in the UK: Systematic review. *British Journal of Psychaitry, 182*, 105-116.

Bindman, J., Reid, Y., Szmukler, G., Tiller, J., Thornicroft, G. & Leese, M. (2005). Perceived coercion at admission to psychiatric hospital and engagement with follow-up: A cohort study. *Social Psychiatry and Psychiatric Epidemiology, 40*(2), 160-166.

Bracken, P. & Thomas, P. (2001). Postpsychiatry: A new direction for mental health. *British Medical Journal, 322*, 724-727.

Bradburn, N. M. (1983). Response effects. In P.H. Rossi, J.D. Wright, & A.B. Anderson (Eds.) *Handbook of survey research.* London: Academic Press.

Braun, V., and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*. 3, 77 – 101.

Brody, E. B. (1995) Editorial: The humanity of psychotic persons and their rights. *The Journal of Nervous and Mental Disease, 183*, 193–194.

Burns, T., Yeelese, K., Molodynski, A., Nightingale, H., Vazquez-Montes, M., Sheeha, K. & Linsell, L. (2011). Pressures to adhere to treatment ('leverage') in English mental healthcare. *British Journal of Psychiatry, 199*, 145-150.

Care Quality Commission (2013). Mental Health Act Annual Report 2011/12. Retrieved on 16th March 2013 from: http://www.cqc.org.uk/public/reports-surveys-and-reviews/reports/mental-health-act-annual-report-2011/12

Cascardi, M. & Poythress, N.G. (1997). Correlates of perceived coercion during psychiatric hospital admission. *International Journal of Law and Psychiatry, 20*(4), 445-458.

Chamberlin, J. (1997). A working definition of empowerment. *Psychiatric Rehabilitation Journal, 20*(4), 43-46.

Charmaz, C. (2006). *Constructing Grounded Theory: A practical guide through qualitative analysis.* London: Sage.

Cicourel, A.V. (1982). Interviews, surveys, and the problem of ecological validity. *The American Sociologist, 17*, 11-20.

County Asylums Act 1845. (1845). (8 & 9 Victoria, c. 126).

Cromby, J. Harper, D. & Reavey, P. (2013). *Psychology, Mental Health, and Distress.* Hampshire: Palgrave MacMillan.

Curtis, L.C. &Diamond, R. (1997). Power and coercion in mental health practice. In B. Blackwell (Ed.) *Treatment Compliance and the Therapeutic Alliance.* Amsterdam: Harwood Academic Publishers.

Davidson, G. & Campbell, J. (2007). An examination of the use of coercion by assertive outreach and community mental health teams in Northern Ireland. *British Journal of Social Work, 37*(3), 537-555.

Department of Health. (1999). Report of the Expert Committee: Review of the Mental Health Act 1983. Retrieved on 22nd February 2013 at: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009576

Department of Health (2003). *Delivering Race Equality – A Framework for Action: Mental health services consultation document.* London: Department of Health.

Department of Health. (2013). *2013/14 Choice Framework.* Retrieved on 9th April 2013 from: http://www.nhs.uk/choiceinthenhs/Pages/Choicehome.aspx

Department of Health Information Centre. Statistical bulletins 1986-2010. Retrieved on 3rd February 2013 from: http://www.statistics.gov.uk/hub/release-calendar/index.html?newquery=*&uday=0&umonth=0&uyear=0&title=In-patients+formally+detained+in+hospitals+under+the+Mental+Health+Act%2C+1983&pagetype=calendar-entry&lday=&lmonth=&lyear=

Department of Health. (1999). Managing dangerous people with severe personality disorder. London: Home Office.

Deutsch, M. (2000). Justice and Conflict. In M. Deutsch & P.T. Coleman (Eds.) *The Handbook of Conflict Resolution: Theory and Practice*. San Francisco: Jossey-Bass Inc.

Elliott, R., Fischer, C.T., & Rennie, D.L. (1999). Evolving guidelines for publications of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*, 215-229.

Foucault, M. (1971). *Madness and civilization: A history of insanity in the age of reason.* London: Tavistock.

Freyenhagen, F. & O'Shea, T. (2013). Hidden substance: Mental disorder as a challenge to normatively neutral accounts of autonomy. *International Journal of Law in Context, 9*, 53-70.

Gardner, W., Hoge, S.K., Bennett, N.S., Roth, L.H., Lidz, C.W., Monahan, J., & Mulvey, E.P. (1993). Two scales for measuring patients' perceptions of coercion during mental hospital admission. *Behavioural Sciences and the Law, 11*, 307-321.

Gault, I. (2009). Service-user and carer perspectives on compliance and compulsory treatment in community mental health services. *Health & Social Care in the Community, 17*(5), 504-513.

Gilburt, H., Rose, D. & Slade, M. (2008). The importance of relationships in mental health care: A qualitative study of service users' experiences of psychiatric hospital admission in the UK. *BMC Health Services Research, 8*, 92-104.

Glaser, B.G., & Strauss, A.L. (1965). *Awareness of dying.* Chicago: Aldine.

Glaser, B.G., & Strauss, A.L. (1967). *The discovery of grounded theory.* Chicago: Aldine.

Grounds, A. (2001). Reforming the Mental Health Act. *British Journal of Psychiatry, 179*, 387-389.

Halpern, A. & Szmukler, G. (1997). Psychiatric advance directives: Reconciling autonomy and non-consensual treatment. *The Psychiatrist, 21*, 323-327.

Hannigan, B. & Cutcliffe, J. (2002). Challenging contemporary mental health policy: Time to assuage the coercion?. *Journal of Advanced Nursing, 37*(5), 477-484.

Harper, D.J. (2004). Storying policy: Constructions of risk in proposal to reform UK mental health legislation. In B. Hurwitz, V. Skultans and T. Greenhalgh (Eds.) *Narrative research in health and illness*. London: BMA Books.

Harper, D. (2012). Choosing a qualitative research method. In D. Harper & A.R. Thompson (Eds.) *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*. Chichester: Wiley-Blackwell.

Harper, D. & Thompson, A.R. (2012). Introduction. In D. Harper & A.R. Thompson (Eds.) *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*. Chichester: Wiley-Blackwell.

Henderson, C., Flood, C., Leese, M., Thornicroft, G., Sutherby, K. & Szmukler, G. (2009). Views of service users and providers on joint crisis plans. *Social Psychiatry and Psychiatric Epidemiology, 44*(5), 369-376.

Henwood, K. L., & Pigeon, N. F. (1992). Qualitative research and psychological theorising. *British Journal of Psychology, 83*(1), 97-112.

HMSO (1957). Royal commission on the law relating to mental illness and mental deficiency (The Percy Commission), Cmnd 169.

Hoge, S.K., Lidz, C.W., Eisenberg, M., Gardner, W., Monahan, J., Mulvey, E., Roth, L. & Bennett, N. (1997). Perceptions of coercion in the admission of

voluntary and involuntary psychiatric patients. *International Journal of Law and Psychiatry, 20*, 167-181.

Hoge, S.K., Lidz, C., Mulvey, E. & Roth, L. (1993). Patient, family, and staff perceptions of coercion in mental hospital admission: An exploratory study. *Behavioral Sciences & the Law, 11*(3), 281-293.

Horowitz, M., Wilner, N., & Alvarez, W. (1979). Impact of events scale: A measure of subjective stress. *Psychosomatic Medicine, 41*, 209–218.

Høyer, G., Kjellin, L., Engberg, M., Kaltiala-Heino, R., Nilstun, T., Sigurjonsdottir, M. & Syse, A. (2002). Paternalism and autonomy: A presentation of a nordic study on the use of coercion in the mental health care system. *International Journal of Law and Psychiatry, 25*(2), 93-108.

Hughes, R., Hayward, M. & Finlay, W.M.L. (2009). Patients' perceptions of the impact of involuntary inpatient care on self, relationships and recovery. *Journal of Mental Health, 18*(2), 152-160.

Jackson, J.S., Torres, M., Caldwell, C.H., Neighbors, H.W., Nesse, R.M., Taylor, R.J., Trierweiler, S.J., & Williams, D.R. (2004). The National Survey of American Life: A study of racial, ethnic and cultural influences on mental disorders and mental health. *International Journal of Methods of Psychiatric Research, 13*(4), 196-207.

Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma.* New York: The Free Press.

Joffe, H. (2012). Thematic Analysis. In D. Harper & A.R. Thompson (Eds.) *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*. Chichester: Wiley-Blackwell.

Johnsen, L., Øysæd, H., Børnes, K., Moe, T.J. & Haavik, J. (2007). A systematic intervention to improve patient information routines and satisfaction in a psychiatric emergency unit. *Nordic Journal of Psychiatry, 61*(3), 213-218.

Johnson, P. (1976). Women and power: Toward a theory of effectiveness. *Journal of Social Issues, 32*, 99–110.

Kallert, T. W. (2008). Coercion in psychiatry. *Current Opinion in Psychiatry, 21*(5), 485-489.

Kallert, T.W., Rymaszewska, J. & Torres-González, F. (2007). Differences of legal regulations concerning involuntary psychiatric hospitalization in twelve European countries: Implications for clinical practice. *International Journal of Forensic Mental Health, 6*, 197-207.

Kaltiala-Heino, R., Laippala, P. & Salokangas, R.K.R. (1997). Impact of coercion on treatment outcome. *International Journal of Law and Psychiatry, 20*(3), 311-322.

Kashima, Y., Yamaguchi, S., Kim, U., Choi, S-C., Gelfand, M.J & Yuki, M. (1995). *Journal of Personality and Social Psychology, 69*(5), 925-937.

Katsakou, C., Marougka, S., Garabette, J., Rost, F., Yeeles, K. & Priebe, S. (2011). Why do some voluntary patients feel coerced into hospitalisation? A mixed-methods study. *Psychiatry Research, 187*, 275-282.

Katsakou, C. & Priebe, S. (2006) Outcomes of involuntary hospital admission - a review. *Acta Psychiatrica Scandinavica, 114*(4), 232-241.

Katsakou, C. & Priebe, S. (2007). Patient's experiences of involuntary hospital admission and treatment: A review of qualitative studies. *Epidemiologia e Psichiatria Sociale, 16*(2), 172-178.

Kazdin, A. E. (2006) Arbitrary metrics: Implications for identifying evidence-based treatments. *American psychologist, 61,* 42-49.

Kjellin, L., Andersson, K., Bartholdson, E., Candefjord, I.L., Holmstrom, H., Jacobsson, L., Sandlund, M., Wallsten, T. & Ostman, M. (2004). Coercion in

psychiatric care - patients' and relatives' experiences from four Swedish psychiatric services. *Nordic Journal of Psychiatry, 58*(2), 153-159.

Kuosmanen, L., Hätönen, H., Malkavaara, H., Kylmä, J. & Välimäki, M. (2007). Deprivation of liberty in psychiatric hospital care: The patient's perspective. *Nursing Ethics, 14*, 587-607.

Laugharne, R., Priebe, S., McCabe, R., Garland, N. & Clifford, D. (2012). Trust, choice and power in mental health care: Experiences of patients with psychosis. *International Journal of Social Psychiatry, 58*(5), 496-504.

Laurance J. (2003). *Pure Madness How Fear Drives the Mental Health System*. London: Routledge.

Lidz, C.W., Hoge, S.K., Gardner, W. Garder, N.S. Bennett, J. Monahan, E.P. Mulvey & L.H. Roth. (1995). Perceived coercion in mental hospital admission: Pressures and process. *Archives of General Psychiatry, 52*(12), 1034-1039.

Link, B., Castille, D.M. & Stuber, J. (2008). Stigma and coercion in the context of outpatient treatment for people with mental illnesses. *Social Science & Medicine, 67*(3), 409-419.

Lovell, A. (1996). Coercion and social control: A framework for research on aggressive strategies in community mental health. In D. Dennis & J. Monahan (Eds.) *Coercion and Aggressive Community Treatment: A New Frontier in Mental Health Law.* New York: Plenum Press.

Lunacy Act 1890. (1890). (53 Victoria, c. 5).

Madill, A., Jordan, A. & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: realist, contextual and radical constructionist epistemologies. *British Journal of Psychology, 91*, 1-20.

Maiese, M. (2004). *Procedural Justice*. Retrieved on 19th January 2013 from: http://www.beyondintractability.org/bi-essay/procedural-justice.

Masson, J.M. (1988). *Against Therapy.* Monroe: Common Courage Press.

Mental Capacity Act 2005. (2005). London: Stationary Office.

Mental Health Act 1959. (1959). London: Stationary Office.

Mental Health Act 1983. (1983). London: Stationary Office.

Mental Health Act 2007. (2007). London: Stationary Office.

Mental Health Foundation. (2012). The Mental Health Strategy: What do we know so far? Retrieved on 19th April 2013 from: http://www.mentalhealth.org.uk/our-news/news-archive/2012/12-01-16a/

Menzies Lyth, I. (1960). A case-study in the functioning of social defence systems as a defence against anxiety: A report on the study of a nursing service of a general hospital. *Human Relations, 13*(1), 95-121.

Monahan, J., Hoge, S.K., Lidz, C., Roth, L.H., Bennett, N., Gardner, W. & Mulvey, E. (1995). Coercion and commitment: Understanding involuntary mental-hospital admission. *International Journal of Law and Psychiatry, 18*(3), 249-263.

Monahan, J., Hoge, S.K., Lidz, C.W., Eisenberg, M.M., Bennett, N.S., Gardner, W.P., Mulvey, E.P. and Roth, L.H. (1996). Coercion to inpatient treatment: Initial results and implications for assertive treatment in the community. In D.L. Dennis, & J. Monahan (Eds.) *Coercion and aggressive community treatment: A new frontier in mental health law.* New York: Plenum Press.

Monahan, J., Redlich, A.D., Swanson, J., Robbins, P.C., Appelbaum, P.S., Petrila, J., Steadman, H.J., Swartz, M., Angell, B. & McNiel, D.E. (2005). Use of leverage to improve adherent to psychiatric treatment in the community. *Psychiatric Services, 56*, 37-44.

Morrison, A.P., Bowe, S., Larkin, W., & Nothard, S. (1999). The psychological impact of psychiatric admission: Some preliminary findings. *Journal of Nervous and Mental Disease, 187*, 250–253.

Mullen, P.E. (1999). Editorial: Dangerous people with severe personality disorder. *British Medical Journal, 319*, 1146.

NACRO (2007). *Black communities, Mental Health and the Criminal Justice System*. Mental Health and Crime Briefing.

Newton-Howes, G. & Mullen, R. (2011). Coercion in psychiatric care: Systematic review of correlates and themes. *Psychiatric Services, 62*(5), 465-470.

Newton-Howes, G. & Stanley, J. (2012). Prevalence of perceived coercion among psychiatric patients: Literature review and meta-regression modelling. *The Psychiatrist, 36*, 335-340.

O'Donoghue, B., Lyne, J., Hill, M., Larkin, C., Feeney, L. & O'Callaghan, E. (2011). Physical coercion, perceived pressures and procedural justice in the involuntary admission and future engagement with mental health services. *European Psychiatry, 26*(4), 208-214.

Opie, A. (1992). Qualitative research: Appropriation of the “other” and empowerment. *Feminist Review, 40*, 52-69.

Oxford English Dictionary. 2nd ed. (1989). Oxford: Clarendon Press.

Patel, M.X., de Zoysa, N., Bernadt, M., Bindman, J. & David, A.S. (2010). Are depot antipsychotics more coercive than tablets? The patient's perspective. *Journal of Psychopharmacology, 24*(10), 1483-1489.

Porter, R. *A social history of madness: Stories of the insane.* London: Weidenfield and Nicolson.

Potter, J. & Hepburn, A. (2005). Qualitative interviews in psychology: problems and possibilities. *Qualitative Research in Psychology, 2*, 281-307.

Priebe, S., Broker, M., & Gunkel, S. (1998). Involuntary admission and posttraumatic stress Relationships between trauma and psychosis 351disorder symptoms in schizophrenia patients. *Comprehensive Psychiatry, 39*, 220–224.

Priebe, S., Katsakou, C., Amos, T., Leese, M., Morriss, R., Rose, D., Wykes, T. & Yeeles, K. (2009). Patients' views and readmissions 1 year after involuntary hospitalisation. *British Journal of Psychiatry, 194*(1), 49-54.

Race Equality Foundation (2007). *African and Caribbean Men and Mental Health.* London: Race Equality Foundation.

Read, J., van Os, J., Morrison, A.P & Ross, C.A. (2005). Childhood trauma, psychosis and schizophrenia: A literature review with theoretical and practical implications. *Acta Psychiatrica Scandinavica, 112*(5), 330-350.

Richardson, G. (2008) 'Coercion and human rights: A European perspective'. *Journal of Mental Health, 17*(3), 245-254.

Rooney, S., Murphy, K. C., Mulvaney, F., & O'Callaghan, E. (1996). A comparison of voluntary and involuntary patients admitted to hospital. *Irish Journal of Psychological Medicine, 13*, 132–137.

Rose, D.S., Wykes, T.H., Bindman, J.P. & Fleischmann, P.S. (2005). Information, consent and perceived coercion: Patients' perspectives on electroconvulsive therapy. *British Journal of Psychiatry, 186*, 54-59.

Rose, G. (1997) Situating knowledges: Positionality, reflexivities and other tactics. *Progress in Human Geography, 21*(3), 305-332.

Rosenhan, D.L. (1973). On being sane in insane places. *Science, 179*, 250-258.

Rugkasa, J. & Canvin, K. (2011). Researching Mental Health in Minority Ethnic Communities: Reflections on recruitment. *Qualitative Health Research, 21*(1), 132-143.

Runswick-Cole, K. (2011). Interviewing. In P. Banister, G. Bunn, E. Burman, J. Daniels, P. Duckett, D. Goodley, R. Lawthom, I. Parker, K. Runswick-Cole, J. Sizsmith, S. Smailes, C. Tindall, & P. Whelan (Eds.) *Qualitative Methods in Psychology: A researcher guide*, 2nd Edition. Maidenhead: Open University Press, McGraw-Hill Education.

Russell, M., Moralejo, D.G., and Burgess, E.D. (2000). Paying research subjects: participants' perspectives. *Journal of Medical Ethics, 26*, 126-130.

Salize, H.J. & Dressing, H. (2004). Epidemiology of involuntary placement of mentally ill people across the European Union. *The British Journal of Psychiatry, 184*, 163-168.

Sampson, E.E. (1993). Identity politics: Challenges to psychology's understanding. *American Psychologist, 48*, 1219-1230.

Schuman, H., & S. Presser. (1981). *Questions and Answers in Attitude Surveys*. New York: Academic Press.

Schwandt, T.A. (2003).Three epistemological stances for qualitative inquiry: Interpretativism, hermeneutics and social constructionism. In N. Denzin & Y. Lincoln, (Eds.) *The Landscape of Qualitative Research: Theories and issues.* Thousand Oaks, CA: Sage.

Scull, A.S. (1979). *Museums of madness: the social organisation of insanity in nineteenth century England.* London: Allen Lane.

Sheehan, K.A. (2009). Compulsory treatment in psychiatry. *Current Opinion in Psychiatry, 22*(6), 582-586.

Sheehan, K.A. & Burns, T. (2011). Perceived coercion and the therapeutic relationship: A neglected association. *Psychiatric Services, 62*(5), 471-476.

Sibitz, I., Scheutz, Lakeman, R., Schrank, B., Schaffer, M., & Amering, M. (2011). Impact of coercive measures on life stories: Qualitative study. *The British Journal of Psychiatry, 199*, 239-244.

Simpson, A. & Janner, M. (2010). *Star Wards Survey Report 2009/2010*. Bright: London.

Smail, D. (2003). Psychotherapy, society and the individual. In Y. Bates, & R. House (Eds.) *Ethically Challenged Professionals*. Ross-on-Wye: PCCS Books.

Sørgaard, K.W. (2007). Satisfaction and coercion among voluntary, persuaded/pressured and committed patients in acute psychiatric treatment. *Scandinavian Journal of Caring Sciences, 21*(2), 214-219.

Speak Out Against Psychiatry. (2013). *How to escape from a psychiatric hospital.* Retrieved on 3rd April 2013 from: http://speakoutagainstpsychiatry.org/how-to-escape-from-a-psychiatric-hospital/

Spencer, L. and Richie, J. (2012). In pursuit of quality. In D. Harper & A.R. Thompson (Eds.) *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*. Chichester: Wiley-Blackwell.

Swanson, J.W., Swartz, M.S., Elbogen, E.B., Van Dorn, R.A., Wagner, H.R., Moser, L.A., Wilder, C. & Gilbert, A.R. (2008). Psychiatric advance directives and reduction of coercive crisis interventions. *Journal of Mental Health, 17*(3), 255-267.

Swanson, J.W., Van Dorn, R.A., Monahan, J. & Swartz, M.S. (2006). Violence and leveraged community treatment for persons with mental disorders. *American Journal of Psychiatry, 163*(8), 1404-1411.

Swartz, M.S., Wagner, H.R., Swanson, J.W., Hiday, V.A. & Burns, B.J. (2002). The perceived coerciveness of involuntary outpatient commitment: Findings from an experimental study. *Journal of the American Academy of Psychiatry and the Law, 30*(2), 207-217.

Swartz, M.S., Swanson, J.W. & Hannon, M.J. (2003). Does fear of coercion keep people away from mental health treatment? Evidence from a survey of persons with schizophrenia and mental health professionals. *Behavioural Sciences and the Law, 21*, 459-472.

Swartz, M.S., Wagner, H.R., Swanson, J.W. & Elbogen, E.B. (2004). Consumers' perceptions of the fairness and effectiveness of mandated community treatment and related pressures. *Psychiatric Services, 55*(7), 780-785.

Szasz, T. (1961). *The myth of mental illness.* New York: Harper and Row.

Szmukler, G. (2003). Risk assessment: 'numbers' and 'values'. *Psychiatric Bulletin, 27*, 205-207.

Szmukler, G. (2008). Treatment pressures, coercion and compulsion in mental health care. *Journal of Mental Health, 17*(3), 229-231.

Szmukler, G. (2013). Fifty years of mental health legislation: Paternalism, bound and unbound. In S. Bloch, J. Holmes & S. Green (Eds.) *Psychiatry: Past, present and prospects*. Oxford: Oxford University Press.

Szmukler, G. & Appelbaum, P.S. (2008). Treatment pressures, leverage, coercion, and compulsion in mental health care. *Journal of Mental Health, 17*(3), 233-244.

Tekkas, K. & Bilgin, H. (2010). Professional containment methods used in psychiatry wards: Justifications for their utilization, types, international practices, and perceptions. *Turk Psikiyatri Dergisi, 21*(3), 235-242.

Thogersen, M.H., Morthorst, B. & Nordentoft, M. (2010). Perceptions of coercion in the community: A qualitative study of patients in a danish assertive community treatment team. *Psychiatric Quarterly, 81*(1), 35-47.

Trochim, W., Dumont, J., & Campbell, J. (1993). *Mapping Mental Health Outcomes from the Perspective of Consumers/Survivors.* Alexandria, VA: National Association of State Mental Health Program Directors, Research Institute.

Tschopp, M.K., Berven, N.L. & Chan, F. (2011). Consumer perceptions of assertive community treatment interventions. *Community Mental Health Journal, 47*(4), 408-414.

Wallsten, T., Kjellin, L. & Lindstrom, L. (2006). Short-term outcome of inpatient psychiatric care: Impact of coercion and treatment characteristics. *Social Psychiatry and Psychiatric Epidemiology, 41*(12), 975-980.

Walonick, D. (1993). *StatPac Gold IV: Survey & Marketing Research Edition*. Minneapolis, MN: StatPac Inc.

Watts, J. & Priebe, S. (2002). A phenomenological account of users' experiences of assertive community treatment. *Bioethics, 16*(5), 439-454.

Wertheimer, A. (1987). *Coercion.* Princeton: Princeton University Press.

White, M., and Epston, D. (1990). *Narrative means to therapeutic ends.* London: Norton.

Whittington, R., Bowers, L., Nolan, P., Simpson, A. & Neil, L. (2009). Approval ratings of inpatient coercive interventions in a national sample of mental health service users and staff in England. *Psychiatric Services, 60*(6), 792-798.

Willig, C. (2008) *Introducing qualitative research in psychology: Adventures in theory and method,* 2nd Ed.) Berkshire: Open University Press.

Yeeles, K., Burns, T., Molodynski, A. & Vazquez-Montes, M. (2011). Use of informal coercion in community mental health care. *Psychiatrische Praxis,* 38.

Yin, R.K. (1994). *Case study research: Design and methods.* London: Sage.

Appendices

Appendix A: Literature search details

The following search terms were used in conjunction with the Boolean operators 'And', 'Or': coercion; treatment pressur*; compulsory treatment; threat; persuasive communication; mental health. These terms were used in an attempt to access literature concerning the whole range of treatment pressures applied to mental health service-users.

When the searches yielded more than 1000 titles they were narrowed by relevant qualifiers (e.g. psychiatry, psychology and medical ethics). The titles of 1630 results remaining were eyeballed and those deemed not relevant were discarded. After duplicates had been removed 324 titles remained. 228 of these were generated by the Web of Science search. Only abstracts of the 157 papers written between 2002 and 2012 were read within this particular search due to limited time. In total 263 abstracts were read. On the basis of reading the abstracts 162 of the results were discarded leaving 101 papers that were read in full. Relevance was determined on the basis that papers focused on experiences of pressure or coercion in the context of mental health services.

A review of the reference lists of the 101 papers identified in the literature search yielded further relevant papers. In addition a search using Google Scholar was carried out in order to find other articles that were relevant.

Web of Science (via Web of Knowledge)

Search no.	Search term	No. articles found
S1	Coercion	4308
S2	Treatment pressur*	117,919
S3	Compulsory treatment	891
S4	Threat	57,349
S5	Persuasive communication	697
S6	Mental health	102,986
S7	S1 or S2 or S3 or S4 or S5	180,636
S8	S6 + S7	1599
S9	S8 narrowed to 'psychiatry', 'psychology clinical', 'psychology multidisciplinary', 'nursing', 'psychology social', 'psychology', 'psychology applied', 'family studies', 'ethics', 'women's studies', 'social sciences interdisciplinary', 'medical ethics', 'medicine legal'	977

The titles of the S9 search were eyeballed and those deemed not relevant were discarded. Those discarded were done so for various reasons including: the subject was not related to mental health service users; the focus was on physical health; they were not related to treatment pressures; the focus was on domestic violence; the focus was on substance abuse; they focused on older adults/adolescents. 228 papers remained.
Due to limited time the 71 abstracts of studies which were written prior to 2002 were not read. Therefore 157 abstracts were read, following which 82 were excluded and 75 remained. Those excluded were done so for multiple reasons including: they focused on capacity to consent; violence by mental health service-users; medication adherence etc.

PychINFO and PsychARTICLES (via EBSCO)

Search no.	Search term	No. articles found
S1	Coercion	3517
S2	Treatment pressur*	954
S3	Compulsory treatment	450
S4	Threat	26,566
S5	Persuasive communication	4512
S6	Mental health	364,648
S7	S1 or S2 or S3 or S4 or S5	35,496
S8	S6 + S7	285

The title of S8 were eyeballed leaving 75 titles. Reasons for discarding titles included: a focus on service-user violence; unrelated to coercion; written in a language other than English; focus on substance abuse/domestic violence; forensic/child population etc. Duplicates (i.e. papers found in previous searches) were deleted leaving 53 titles.
The abstracts of the 53 papers remaining were read following which 17 remained. Those discarded were done for reasons including: they did not discuss experiences of coercion; they focused on treatment adherence; learning disability/forensic population.

CINAHL Plus (via EBSCO)

Search no.	Search term	No. articles found
S1	Coercion	1359
S2	Treatment pressur*	2567
S3	Compulsory treatment	140
S4	Threat	6670
S5	Persuasive communication	36
S6	Mental health	65,312
S7	S1 or S2 or S3 or S4 or S5	10,730
S8	S6 + S7	104

The titles of the S8 search were eyeballed. Those discarded were done so various reasons including: they focused on service-user violence/police intervention; they were not related to treatment pressures; focused on substance misuse; carried out with prison population; focused on domestic violence; carried out with learning disabilities population; or they had a medical focus. 48 papers remained. Duplicates (i.e. papers found in previous searches) were deleted leaving 39 titles.
Abstracts of the remaining 39 titles were read, 33 of which were discarded following this. Those that were discarded were done so for reasons including: they were duplicates that had not been picked up previously as the reference had been inputted slightly differently; they were deemed not relevant because they focused on changes in mental health legislation without discussion of pressure/coercion; they were carried out with a learning disabilities population.

Medline (via Web of Knowledge) (1950 – present)

Search no.	Search term	No. articles found
S1	Coercion	4591
S2	Treatment pressur*	320,073
S3	Compulsory treatment	151,376
S4	Threat	34,208
S5	Persuasive communication	2876
S6	Mental health	138,084

S7	S1 or S2 or S3 or S4 or S5	597,002
S8	S6 + S7	264

The titles of the S8 search were eyeballed and none of the 264 papers were deemed relevant as they were not related to the phenomenon of interest.

Literature reviewed but not cited in the main body of this report

Andreasson, E. & Skarsater, I. (2012). Patients treated for psychosis and their perceptions of care in compulsory treatment: Basis for an action plan. *Journal of Psychiatric and Mental Health Nursing, 19*(1), 15-22.

Appelbaum, P. S. & Redlich, A. (2006). Use of leverage over patients' money to promote adherence to psychiatric treatment. *Journal of Nervous and Mental Disease, 194*(4), 294-302.

Bak, J. & Aggernaes, H. (2012). Coercion within danish psychiatry compared with 10 other european countries. *Nordic Journal of Psychiatry, 66*(5), 297-302.

Baker, J. A., Lovell, K., Easton, K. & Harris, N. (2006). Service users' experiences of 'as needed' psychotropic medications in acute mental healthcare settings. *Journal of Advanced Nursing, 56*(4), 354-362.

Bennewith, O., Amos, T., Lewis, G., Katsakou, C., Wykes, T., Morriss, R. & Priebe, S. (2010). Ethnicity and coercion among involuntarily detained psychiatric in-patients. *British Journal of Psychiatry,* 196(1), 75-76.

Berghmans, R. & van der Zanden, M. (2012). Choosing to limit choice: Self-binding directives in dutch mental health care. *International Journal of Law and Psychiatry,* 35(1), 11-18.

Boydell, J., Morgan, C., Dutta, R., Jones, B., Alemseged, F., Dazzan, P., Morgan, K., Doody, G., Harrison, G., Leff, J., Jones, P., Murray, R. & Fearon, P. (2012). Satisfaction with inpatient treatment for first-episode psychosis among different ethnic groups: A report from the UK SOP study. *International Journal of Social Psychiatry,* 58(1), 98-105.

Canvin, K., Bartlett, A. & Pinfold, V. (2005). Acceptability of compulsory powers in the community: The ethical considerations of mental health service users on supervised discharge and guardianship. *Journal of Medical Ethics,* 31(8), 457-462.

Cleary, M., Hunt, G. E. & Walter, G. (2010). Seclusion and its context in acute inpatient psychiatric care. *Journal of Medical Ethics,* 36(8), 459-462.

Crilly, J. R. (2008). An overview of compulsory, noncompulsory, and coercive interventions for treating people with mental disorders in the united states. *International Journal of Mental Health,* 37(3), 57-80.

Davis, S. (2002). Autonomy versus coercion: Reconciling competing perspectives in community mental health. *Community Mental Health Journal,* 38(3), 239-250.

Diseth, R.R., Bøgwald, K.P. & Høglend, P.A. (2011). Attitudes among stakeholders towards compulsory mental health care in norway. *International Journal of Law and Psychiatry, 34*(1), 1-6.

Fiorillo, A., De Rosa, C., Del Vecchio, V., Jurjanz, L., Schnall, K., Onchev, G., Alexiev, S., Raboch, J., Kalisova, L., Mastrogianni, A., Georgiadou, E., Solomon, Z., Dembinskas, A., Raskauskas, V., Nawka, P., Nawka, A., Kiejna, A., Hadrys, T., Torres-Gonzales, F., Mayoral, F., Bjorkdahl, A., Kjellin, L., Priebe, S., Maj, M. &

Kallert, T. (2011). How to improve clinical practice on involuntary hospital admissions of psychiatric patients: Suggestions from the eunomia study. *European Psychiatry,* 26(4), 201-207.

Frueh, B. C., Knapp, R. G., Cusack, K. J., Grubaugh, A. L., Sauvageot, J. A., Cousins, V. C., Yim, E., Robins, C. S., Monnier, J. & Hiers, T. G. (2005). Special section on seclusion and restraint: Patients' reports of traumatic or harmful experiences within the psychiatric setting. *Psychiatric Services,* 56(9), 1123-1133.

Galon, P. A. & Wineman, N. M. (2010). Coercion and procedural justice in psychiatric care: State of the science and implications for nursing. *Archives of Psychiatric Nursing,* 24(5), 307-316.

Galon, P. A., Wineman, N. M. & Grande, T. (2012). Influence of race on outpatient commitment and assertive community treatment for persons with severe and persistent mental illness. *Archives of Psychiatric Nursing,* 26(3), 202-213.

Gardner, A. (2010). Therapeutic friendliness and the development of therapeutic leverage by mental health nurses in community rehabilitation settings. *Contemporary Nurse: A Journal for the Australian Nursing Profession,* 34(2), 140-148.

Gilbert, C. & Plant, N. (2010). Supervised community treatment brings changes to the nurse's role. *Mental Health Practice,* 13(6), 31-34.

Greenberg, D., Mazar, J., Brom, D. & Barel, Y. C. (2005). Involuntary outpatient commitment: A naturalistic study of its use and a consumer survey at one community mental health center in Israel. *Medicine & Law,* 24(1), 95-110.

Happell, B. & Harrow, A. (2010). Nurses' attitudes to the use of seclusion: A review of the literature. *International Journal of Mental Health Nursing,* 19(3), 162-168.

Heffern, W. A. & Austin, W. (1999). Compulsory community treatment: Ethical considerations. *Journal of Psychiatric & Mental Health Nursing,* 6(1), 37-42.

Husum, T.L., Bjorngaard, J.H., Finset, A. & Ruud, T. (2011). Staff attitudes and thoughts about the use of coercion in acute psychiatric wards. *Social Psychiatry and Psychiatric Epidemiology, 46*(9), 893-901.

Jaeger, M. & Rossler, W. (2010). Enhancement of outpatient treatment adherence patients' perceptions of coercion, fairness and effectiveness. *Psychiatry Research,* 180(1), 48-53.

Jarrett, M., Bowers, L. & Simpson, A. (2008). Coerced medication in psychiatric inpatient care: Literature review. *Journal of Advanced Nursing,* 64(6), 538-548.

Katsakou, C., Bowers, L., Amos, T., Morriss, R., Rose, D., Wykes, T. & Priebe, S. (2010). Coercion and treatment satisfaction among involuntary patients. *Psychiatric Services,* 61(3), 286-292.

Kelly, B. D. (2011). Mental health legislation and human rights in england, wales and the republic of ireland. *International Journal of Law and Psychiatry,* 34(6), 439-454.

Khazaal, Y., Chatton, A., Pasandin, N., Zullino, D. & Preisig, M. (2009). Advance directives based on cognitive therapy: A way to overcome coercion related problems. *Patient Education and Counseling,* 74(1), 35-38.

Kjellin, L. & Wallsten, T. (2010). Accumulated coercion and short-term outcome of inpatient psychiatric care. *Bmc Psychiatry,* 10.

Kjellin, L. & Westrin, C.G. (1998). Involuntary admissions and coercive measures in psychiatric care: Registered and reported. *International Journal of Law and Psychiatry,* 21(1), 31-42.

Lay, B., Lauber, C. & Rossler, W. (2005). Are immigrants at a disadvantage in psychiatric in-patient care?. *Acta Psychiatrica Scandinavica,* 111(5), 358-366.

Lay, B., Nordt, C. & Rossler, W. (2011). Variation in use of coercive measures in psychiatric hospitals. *European Psychiatry,* 26(4), 244-251.

Livingston, J. (2012). Self-stigma and quality of life among people with mental illness who receive compulsory community treatment services. *Journal of Community Psychology,* 40(6), 699-714.

Lutzen, K. (1998). Subtle coercion in psychiatric care. *Journal of Psychiatric and Mental Health Nursing, 5*, 101-107.

McKenna, B. G., Simpson, A. I. F. & Coverdale, J. H. (2006). Best practice management strategies for mental health nurses during the clinical application of civil commitment: An overview. *Contemporary Nurse,* 21(1), 62-70.

McKenna, B. G., Simpson, A. I. F. & Laidlaw, T. M. (1999). Patient perception of coercion on admission to acute psychiatric services: The New Zealand experience. *International Journal of Law and Psychiatry,* 22(2), 143-153.

Mfoafo-M'Carthy, M. & Williams, C. C. (2010). Coercion and community treatment orders (CTOs): One step forward, two steps back?. *Canadian Journal of Community Mental Health,* 29(1), 69-80.

Monahan, J., Redlich, A. D., Swanson, J., Robbins, P. C., Appelbaum, P. S., Petrila, J., Steadman, H., Swartz, M., Angell, B. & McNiel, D. E. (2005). Use of leverage to improve adherence to psychiatric treatment in the community. *Psychiatric Services,* 56(1), 37-44.

Norredam, M., Garcia-Lopez, A., Keiding, N. & Krasnik, A. (2010). Excess use of coercive measures in psychiatry among migrants compared with native Danes. *Acta Psychiatrica Scandinavica,* 121(2), 143-151.

O'Brien, A. J. & Golding, C. G. (2003). Coercion in mental healthcare: The principle of least coercive care. *Journal of Psychiatric & Mental Health Nursing,* 10(2), 167-173.

O'Brien, A. J., McKenna, B. G. & Kydd, R. R. (2009). Compulsory community mental health treatment: Literature review. *International Journal of Nursing Studies,* 46(9), 1245-1255.

O'Donoghue, B., Lyne, J., Hill, M., Larkin, C., Feeney, L. & O'Callaghan, E. (2010). Involuntary admission from the patients' perspective. *Social Psychiatry and Psychiatric Epidemiology,* 45(6), 631-638.

O'Reilly, R. L., Keegan, D. L., Corring, D., Shrikhande, S. & Natarajan, D. (2006). A qualitative analysis of the use of community treatment orders in Saskatchewan. *International Journal of Law and Psychiatry,* 29(6), 516-524.

Olofsson, B. & Norberg, A. (2000). Experiences of coercion in psychiatric care as narrated by patients, nurses, physicians. *Issues and Innovations in Nursing Practice,33*(1), 89-97.

Owen, J. L. & Floyd, M. (2010). Negotiated coercion: Thoughts about involuntary treatment in mental health. *Ethics and Social Welfare,* 4(3), 297-299.

Parish, C. (2009). High number of treatment orders sparks call for review. *Mental Health Practice,* 13(4), 7-7.

Patterson, T., Mullen, R., Gale, C. & Gray, A. (2011). Compulsory community treatment and patients' perception of recovery in schizophrenia. *Australasian Psychiatry,* 19(5), 431-438.

Perkins, E., Prosser, H., Riley, D. & Whittington, R. (2012). Physical restraint in a therapeutic setting; a necessary evil?. *International Journal of Law and Psychiatry,* 35(1), 43-49.

Pescosolido, B. A., Gardner, C. B. & Lubell, K. M. (1998). How people get into mental health services: Stories of choice, coercion and 'muddling through' from 'first-timers'. *Social Science & Medicine,* 46(2), 275-286.

Petrila, J. & Manahan, J. (2003). Introduction to this issue: Mandated community treatment. *Behavioral Sciences & the Law,* 21(4), 411-414.

Raboch, J., Kalisova, L., Nawka, A., Kitzlerova, E., Onchev, G., Karastergiou, A., Magliano, L., Dembinskas, A., Kiejna, A., Torres-Gonzales, F., Kjellin, L., Priebe, S. & Kallert, T. W. (2010). Use of coercive measures during involuntary hospitalization: Findings from ten european countries. *Psychiatric Services,* 61(10), 1012-1017.

Rain, S. D., Steadman, H. J. & Robbins, P. C. (2003). Perceived coercion and treatment adherence in an outpatient commitment program. *Psychiatric Services,* 54(3), 399-401.

Rogers, A. (1993). Coercion and 'voluntary' admission: An examination of psychiatric patient views. *Behavioral Sciences & the Law,* 11(3), 259-267.

Romans, S., Dawson, J., Mullen, R. & Gibbs, A. (2004). How mental health clinicians view community treatment orders: A national new zealand survey. *Australian and New Zealand Journal of Psychiatry,* 38(10), 836-841.

Salize, H. J. & Dressing, H. (2005). Coercion, involuntary treatment and quality of mental health care: Is there any link?. *Current Opinion in Psychiatry,* 18(5), 576-584.

Sullivan, W. P. & Carpenter, J. (2010). Community-based mental health services: Is coercion necessary?. *Journal of Social Work in Disability & Rehabilitation,* 9(2-3), 148-167.

Swartz, M. S., Swanson, J. W. & Hannon, M. J. (2003). Does fear of coercion keep people away from mental health treatment? - Evidence from a survey of persons with schizophrenia and mental health professionals. *Behavioral Sciences & the Law,* 21(4), 459-472.

Wallcraft, J. (2012). What has been learned from joint working between mental health professionals, patients and users of psychiatric services, their families and friends?. *Current Opinion in Psychiatry,* 25(4), 317-321.

Wallsten, T., Ostman, M., Sjoberg, R. L. & Kjellin, L. (2008). Patients' and next-of-kins' attitudes towards compulsory psychiatric care. *Nordic Journal of Psychiatry,* 62(6), 444-449.

Wood, D. & Pistrang, N. (2004). A safe place? Service users' experiences of an acute mental health ward. *Journal of Community & Applied Social Psychology,* 14(1), 16-28.

Wynn, R. (2006). Coercion in psychiatric care: Clinical, legal, and ethical controversies. *International Journal of Psychiatry in Clinical Practice,* 10(4), 247-251.

Zinkler, M. & Priebe, S. (2002). Detention of the mentally ill in Europe: A review. *Acta Psychiatrica Scandinavica,* 106(1), 3-8.

ØHlenschlæger, J. & Nordentoft, M. (2008). Coercion in patients who at their first contact with the psychiatric services system were diagnosed within the schizophrenia-spectrum in Denmark. A register study'. *Nordic Journal of Psychiatry,* 62(1), 77-81.

Appendix B: Reflective diary extracts

26/12/12

Today, similarly to other days of both interviewing and transcribing, I am reminded of one of my first jobs on a forensic psychiatric unit and the uncomfortable feelings I have about the system I joined and was a part of there. I feel guilt and regret regarding the events that I both witnessed and participated in. I am particularly reminded of restraining service-users as I transcribe Toby's interview…

08/02/13

I felt very moved by the interview today. Especially by her account of being held down for ECT against her will – the pure fear of being able to do nothing to stop it. She was very lively in her discussion and thoughtful, but at times when she was recounting what seemed like more painful memories she became more still and looked into space whilst talking. It seemed at times painful and difficult for her to go back to those times. I feel privileged that she felt able to tell me these things…

Appendix C: Letter confirming UEL ethical approval

ETHICAL PRACTICE CHECKLIST (Professional Doctorates)

SUPERVISOR: David Harper
STUDENT: Hannah Duncan
ASSESSOR: Max O'Neill
DATE (sent to assessor): 16/03/2012

Proposed research topic: Experiences of coercion and treatment pressures amongst mental health service users.

Course: PROFESSIONAL DOCTORATE IN CLINICAL PSYCHOLOGY (CLINPSYD).

1.	Will free and informed consent of participants be obtained?	YES
2.	If there is any deception is it justified?	N/A
3.	Will information obtained remain confidential?	YES
4.	Will participants be made aware of their right to withdraw at any time?	YES
5.	Will participants be adequately debriefed?	YES
6.	If this study involves observation does it respect participants' privacy?	NA
7.	If the proposal involves participants whose free and informed consent may be in question (e.g. for reasons of age, mental or emotional incapacity), are they treated ethically?	YES
8.	Is procedure that might cause distress to participants ethical?	NA
9.	If there are inducements to take part in the project is this ethical?	YES
10.	If there are any other ethical issues involved, are they a problem?	NA

APPROVED

YES		

MINOR CONDITIONS:
REASONS FOR NON APPROVAL:
Assessor initials: MO'N Date: 16/03/12

RESEARCHER RISK ASSESSMENT CHECKLIST (BSc/MSc/MA)

SUPERVISOR: David Harper **ASSESSOR:** Max O'Neill
STUDENT: Hannah Duncan **DATE (sent to assessor):** 16/03/2012

Proposed research topic: Experiences of coercion and treatment pressures amongst mental health service users.

Course: PROFESSIONAL DOCTORATE IN CLINICAL PSYCHOLOGY (CLINPSYD).
Would the proposed project expose the researcher to any of the following kinds of hazard?

1	Emotional	NO
2.	Physical	NO
3.	Other (e.g. health & safety issues)	NO

If you've answered YES to any of the above please estimate the chance of the researcher being harmed as: HIGH / MED / LOW

APPROVED

YES		

MINOR CONDITIONS:
REASONS FOR NON APPROVAL:
Assessor initials: **MO'N** Date: 16/03/12

SCHOOL OF PSYCHOLOGY
Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.

UEL
University of East London
www.uel.ac.uk

School of Psychology

Professional Doctorate Programmes

To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,

Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

Stratford Campus, Water Lane, Stratford, London E15 4LZ
tel: +44 (0)20 8223 4966 fax: +44 (0)20 8223 4937
e-mail: mno.davies@uel.ac.uk web: www.uel.ac.uk/psychology

Appendix D: Recruitment email

Hello all at XXX,

I hope you don't mind me emailing you.

I am currently doing some research as part of my Doctorate in Clinical Psychology at the University of East London. I have ethical approval from the University to recruit for the study.

I am interested in hearing about a whole range of mental health service-users' experiences of pressure or coercion with regards to their mental health treatment (including medication, psychotherapy, hospitalisation etc.)

I was wondering if you would mind sending an email out to your members with details of the study, to see if they would be interested in taking part. I am also more than happy to attend service-user groups to talk about the research to people.

Below is a summary of the study and what taking part would involve.

I look forward to hearing from you.

Many thanks,
Hannah Duncan

Would you like to take part in a study that is looking at mental health service-users' experiences of treatment pressures?

This study is exploring times when service-users have felt pressured by others with regards to their mental health treatment(s) and how they have made sense of these experiences.

I am interested in hearing about a <u>whole range of experiences</u> – for example; being persuaded to have psychotherapy, being pressurised to take medication or being compulsorily admitted to hospital.

I am happy to meet with people one-to-one or in small groups to hear about their experiences. Depending on the number of people who want to be involved I will offer women only and men only groups if possible. The meetings will last between 1 and 2 hours.

You will be paid **£15** for your time and your travel expenses will be reimbursed if you are able to provide tickets or receipts.

If you are interested in taking part and would like to find out more about the study please email me on:**treatmentpressures@gmail.com**

Thank you.

Hannah Duncan
(Trainee Clinical Psychologist – University of East London)

Appendix E: Participant information sheet

Information Sheet

Experiences of coercion and treatment pressures amongst mental health service users

Consent to Participate in a Research Study
The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study.

What is this project looking at?
This project aims to explore service-users' experiences of coercion and treatment pressures. Coercion is when someone compels another person to act or think in a certain way through the use of pressure, threats, intimidation or force. This study is interested in looking at times when service-users have felt coerced by others with regards to their mental health treatment(s) and what people make of these experiences.

Why is the project being carried out?
There is very little research which has looked at mental health service-users' experiences of pressures or coercion with regards to their treatment(s) (such as medication, psychotherapy and hospitalisation). This study aims to find out more about these experiences and their impact on people. Having a greater knowledge of these issues will hopefully help to improve the experiences of people using mental health services.

Why me?
We are interested in hearing about a whole range of different experiences including both in and out of hospital, and times when people have felt forced into engaging with their treatments as well as when they have felt subtly pressured into doing so.

What will happen if I take part in the project?
You will be asked to attend an interview with the researcher, who will ask you about your of treatment pressures. The interview will last approximately 1-1.5 hours and will be recorded and transcribed by the researcher.

You will be paid £15 for your time in attending the interview. Your travel expenses to the interview will also be reimbursed for if you bring your receipts or tickets with you.

What if I become distressed during the meeting?
The subject area being discussed may be upsetting for you. You are free to leave the study at any time. You are also free to take a break from the interview and return when you feel able to. The investigator can also give you contact details for further support.

What will happen to my confidential information if I decide to take part?
The investigator will not access your medical files. The investigator will ask for you to provide some basic information about yourself at interview such as gender, age, ethnicity, mental health diagnosis/diagnoses and dates of previous hospital admissions for mental health reasons and whether these were under a section or not.

Anonymity will be assured by assigning each participant a code. The codes and consent forms will be kept in a locked cabinet separate to the recordings of the interviews, transcribed materials and basic details about participants (e.g. name, age etc). The researcher will transcribe all of the interviews. All of the identifiable information contained

in the interviews will be anonymised. Only the researcher, supervisors and examiners will have access to the transcribed material. Data will be only accessed via a password on a computer, and will be erased after five years. After examination of the research has been concluded, all digital records will be erased.

What you say in the interview will be kept confidential. Small extracts of what you say may be used as quotes in the final write-up of the project though these will be anonymised. The researcher will only break confidentiality in the unlikely event that they have serious concerns about your safety or the safety of others. The researcher will try and talk to you about breaking confidentiality before they do so if possible.

What are the risks and benefits of me taking part in the study?
As discussed above the issues talked about in the interview may be emotional for you and it is possible that you will think about or even re-experience difficult events that have happened to you in the past.

It might be interesting and helpful to have a space to talk about these types of experiences. The findings of this research might help to change future experiences for you or others involved in mental health services.

Where will the interview take place?
The interview will either take place at the University of East London in Stratford, or a suitable community location (such as a quiet café, library etc.).

What if I change my mind and do not want to be involved in the project at a later date?
You are not obliged to take part in this study, and are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself or your care and you do not have to give a reason for doing so.

Contact for further information
If you would like to take part or have any questions please contact Hannah Duncan on

Email: treatmentpressures@gmail.com

Phone: (University of East London, Doctorate in Clinical Psychology office): 0208 223 4174/4567

What if I have a query/complaint about the way the study is being conducted?

University Research Ethics Committee

If you have any queries or complaints you have regarding the conduct of the programme in which you are being asked to participate, please contact the Secretary of the University Research Ethics Committee, Ms Debbie Dada, Admissions and Ethics Officer, Graduate School, University of East London, Docklands Campus, London E16 2RD (Tel 020 8223 2976, Email: d.dada@uel.ac.uk)

University of East London
Stratford Campus
Water Lane
London
E15 4LZ
Tel: 02082234174

Appendix F: Interview schedule

Definitions of treatment pressures:

- What kinds of experiences do you think are examples of treatment pressures?
- Can you give personal examples? Do any stand out in your mind?
- What were the preceding events? (views on)
- What do you think are the different ways in which treatment pressures can be experienced?
- What makes it feel like a pressure? - The act itself? The way its done? The person who does it? The person who receives it?
- What feels more or less like a treatment pressure and why? Can you give personal examples?
- What is your understanding of why these things happened to you?
- Has this understanding changed over time?

What are the effects of these experiences? Both negative and positive.

- On yourself?
- On your relationships with services and staff?
- On you relationships with families?
- On your relationships with others?
- Have these effects changed over time?

What can be changed?

- What could have been done differently then or can be done differently in the future by staff or service-users?
- How would these changes make these experiences less coercive/pressurised and why?

Black and Minority Ethnic service-users:

- Are these issues different for black and minority ethnic service-users?
- Why and in what ways e.g. racism, diagnosis, violence?

Gender:

- Are these issues different for male/female service-users?
- Why and in what way?

Ending questions:

- What has been helpful in managing your experiences of pressure or coercion?
- Is there anything else you think I should know/understand better?
- Is there anything you would like to ask me?

Role of information: (added later)

- Do you feel you were given enough information with regards to the treatment(s) you received?
- How did this impact on the experience of treatment pressure?

Appendix G: Participant consent form

CONSENT FORM

Title of study:
Experiences of coercion and treatment pressures amongst mental health service users

Identification Number:

Please initial box

1	I confirm that I have read and understand the information sheet relating to this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason for doing so. I understand that withdrawing will not affect my health care in any way.	☐
3	I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. I understand that anonymous extracts or quotes of what I say during the meeting may be written up or published.	☐
4	I agree to take part in the above study.	☐

Name of participant:

Signature:

Date:

Name of researcher:

Signature:

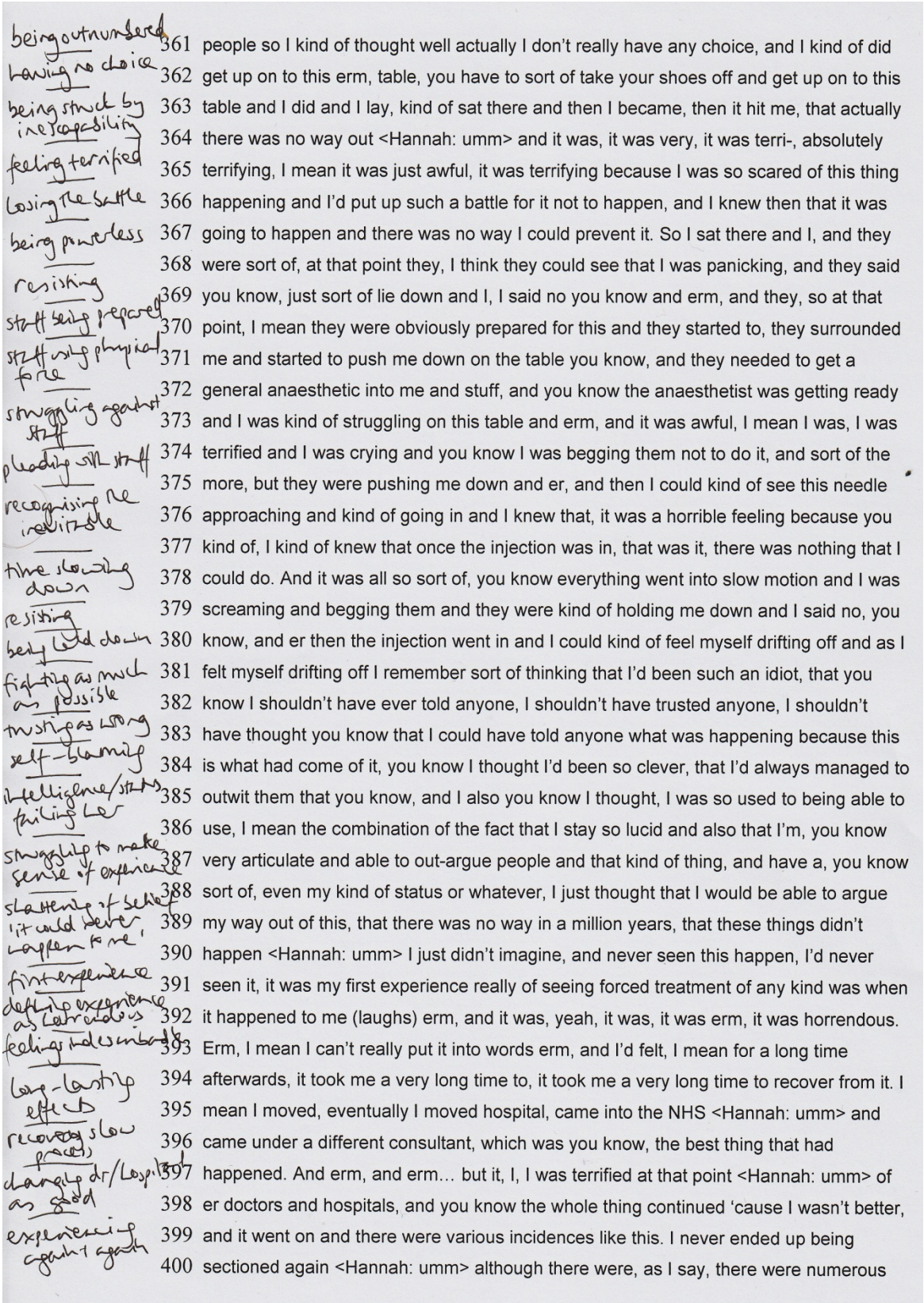
Date:

Appendix H: Transcription conventions

Adapted from Bannister, Burman, Parker, Taylor & Tindall (1994):

Notation:	Explanation:
Participant 1: When I went there [primary school]	Square brackets indicate author's description rather than transcription
Participant 2: you see <Hannah: mm> I was only trying	Indicates overlapping speech where interruption does not affect flow of speaker's speech
Participant 3: and then she/ Hannah: /sorry can I just ask	Indicates overlapping speech where flow of speaker's speech is interrupted
Participant 4: perhaps (laughs)	Indicates speaker laughed
Participant 5: It was…not that long ago	Ellipsis indicates part of the speech has been removed from the extract as it was not deemed relevant to point being illustrated.

Appendix I: Example of line-by-line coding



361 people so I kind of thought well actually I don't really have any choice, and I kind of did
362 get up on to this erm, table, you have to sort of take your shoes off and get up on to this
363 table and I did and I lay, kind of sat there and then I became, then it hit me, that actually
364 there was no way out <Hannah: umm> and it was, it was very, it was terri-, absolutely
365 terrifying, I mean it was just awful, it was terrifying because I was so scared of this thing
366 happening and I'd put up such a battle for it not to happen, and I knew then that it was
367 going to happen and there was no way I could prevent it. So I sat there and I, and they
368 were sort of, at that point they, I think they could see that I was panicking, and they said
369 you know, just sort of lie down and I, I said no you know and erm, and they, so at that
370 point, I mean they were obviously prepared for this and they started to, they surrounded
371 me and started to push me down on the table you know, and they needed to get a
372 general anaesthetic into me and stuff, and you know the anaesthetist was getting ready
373 and I was kind of struggling on this table and erm, and it was awful, I mean I was, I was
374 terrified and I was crying and you know I was begging them not to do it, and sort of the
375 more, but they were pushing me down and er, and then I could kind of see this needle
376 approaching and kind of going in and I knew that, it was a horrible feeling because you
377 kind of, I kind of knew that once the injection was in, that was it, there was nothing that I
378 could do. And it was all so sort of, you know everything went into slow motion and I was
379 screaming and begging them and they were kind of holding me down and I said no, you
380 know, and er then the injection went in and I could kind of feel myself drifting off and as I
381 felt myself drifting off I remember sort of thinking that I'd been such an idiot, that you
382 know I shouldn't have ever told anyone, I shouldn't have trusted anyone, I shouldn't
383 have thought you know that I could have told anyone what was happening because this
384 is what had come of it, you know I thought I'd been so clever, that I'd always managed to
385 outwit them that you know, and I also you know I thought, I was so used to being able to
386 use, I mean the combination of the fact that I stay so lucid and also that I'm, you know
387 very articulate and able to out-argue people and that kind of thing, and have a, you know
388 sort of, even my kind of status or whatever, I just thought that I would be able to argue
389 my way out of this, that there was no way in a million years, that these things didn't
390 happen <Hannah: umm> I just didn't imagine, and never seen this happen, I'd never
391 seen it, it was my first experience really of seeing forced treatment of any kind was when
392 it happened to me (laughs) erm, and it was, yeah, it was, it was erm, it was horrendous.
393 Erm, I mean I can't really put it into words erm, and I'd felt, I mean for a long time
394 afterwards, it took me a very long time to, it took me a very long time to recover from it. I
395 mean I moved, eventually I moved hospital, came into the NHS <Hannah: umm> and
396 came under a different consultant, which was you know, the best thing that had
397 happened. And erm, and erm… but it, I, I was terrified at that point <Hannah: umm> of
398 er doctors and hospitals, and you know the whole thing continued 'cause I wasn't better,
399 and it went on and there were various incidences like this. I never ended up being
400 sectioned again <Hannah: umm> although there were, as I say, there were numerous

Appendix J: Example of focused coding

Hannah: And you feel if you do say that, whether verbally or with protest in action <Susan: you just end up staying longer> Have you had experiences of that?
Susan: Erm, I just imagine that's probably what would happen <Hannah: umm> I mean I have, yeah, I have in the past, tried not cooperating, and you just end up staying longer.
Hannah: So when you, what, what did you do?
Susan: I just stayed in bed all the time, I didn't talk to them. And refused everything that they, you know, that they wanted to do. But erm, as I said it just, it just meant I stayed there longer <Hannah: right> But I did actually erm, that time I did actually win my tribunal. This was about five years ago, five or six years ago. And erm, I won the tribunal that time. But you know, in order to get the tribunal you have to stay in hospital longer than you would normally <Hannah: right> You know, 'cause it takes them about six weeks to organise it, at least that, whereas if you cooperate you might be out in three or four weeks.
Hannah: And what's the effect of that? Do you feel, kind of cooperating, obviously there's the likelihood that you might get out earlier than you would if you didn't <Susan: yeah> erm, but what's the effect of erm, I mean it sounds like you're, you're kind of describing a kind of contradiction sometimes, sometimes you you don't want to cooperate and you may end up winning your tribunal but it means you'll probably stay longer <Susan: yeah> But then there's cooperating and getting out earlier. What do you feel like the effects of cooperating are on you?
Susan: I don't feel that erm, it actually improves my health at all. I don't think it does. I think erm, if I cooperate it just makes me more of a slave than I was otherwise. That's what it feels like, being you know, part of a slave underclass.
Hannah: Umm. Can you say a bit more about that?
Susan: Well you're a slave to the medication you know, you have to turn up and have your injection and, you're a slave to it you know. And you're an underclass because you don't have the rights that anyone else in the society has. You know the right to refuse treatment for a start <Hannah: umm> So it just makes you feel horrible actually, really horrible.
Hannah: So it feels like it's maybe, an effect of these experiences is on your experience of yourself or your identity in some way? <Susan: yeah> Are there other effects on your identity, or effects on your relationships with others, whether they be friends, family, services?
Susan: Well, erm, several of my friends now are, are more erm, are kind of convinced that I need to be taking the drugs. So they, I think that the relationship is deteriorated. I mean I don't argue with them, I just think well, you know, what kind of friend are they to me if they think that I'm different from them in some way? <Hannah: umm> Erm, I don't you know, I feel that, I mean I've got friends now, I've got friends from 'speak out against psychiatry' [service user/survivor group] who don't think like that, you know, don't think like that at all. So that's good <Hannah: um hmm> you know. But I feel with them they

REFUSING TO COMPLY
MAKING A PROTEST?
COMPLYING TO ESCAPE
TREATMENTS UNHELPFUL
SELF-IDENTITY
CLASS CONTEXT
FEELING HORRIBLE
IMPACTING ON RELATIONSHIPS
SEEKING PEER SUPPORT

Appendix K: Example memo

Memo: Taking control 03/03/13

Over the course of the last few weeks, reading and re-reading the interview transcripts I am struck by the devastation that experiencing treatment pressures can cause in people's views of themselves, their views of and interactions within the world and in their relationships. Yet I also hear a call in some, though definitely not all of the interviews, for a need for these treatment pressures – they keep people alive.

It seems that being made to do something you don't want to do can have quite horrific processes. Listening to Amelia describe her experiences of forced ECT and reading them over again makes me feel quite disturbed and horrified. Yet there is something that keeps her returning to services and I feel that is the way in which she has **TAKEN CONTROL** of her relationship with services, with treatments and with treatment pressures. She has put herself back in the driving seat by "coming full circle and harnessing coercion". She has **chosen coercion**.

Her use of the words "coming full circle" suggest to me a process over time, a learning process, within which she has been able to incorporate her experiences into her understanding of the world, herself, those around her, and the relationships between. Perhaps life would be too difficult to bear, understandably I think, if one couldn't make sense of what was happening and completely lost control.

I then find myself thinking about the other narratives I have heard – in what ways have they **TAKEN CONTROL**?

Jane has talked very openly about **escaping**, which Mark has alluded to too.
Others, Christine, Susan, Toby have chosen to **fight** the system and **be activists** against the use of treatment pressures. They have also all sought like-minded people to join them on their lonely venture against the BIG SYSTEM.

I read back over this page and I think of Jane's quote "fight, flight or comply" as **survival strategies**. Maybe in the face of these difficult experiences of treatment pressures people need to **TAKE CONTROL** as a way of **surviving**. But people can do this in different ways: **choose coercion and comply; fight, flight and escape; or seek** (I have heard different types of seeking: seeking like-minded communities, seeking information, seeking alternative help).